Medical Consent Form

NAME OF PARTICIPANT (printed): _____

NAME OF PARENT OR GUARDIAN (printed): _____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named below as the "participant") or in the event of illness of myself, my spouse or any child of mine while in, on or about the premises at Lake Merced or while participating in any activity sponsored by or under the auspices of San Francisco State University and the Recreation and Parks Department of the City of SanFrancisco under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.
2. I authorize any agent of San Francisco State University to consent to such medical care, attention or treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost San Francisco State University, The city of San Francisco, the San Francisco Recreation and Parks Department, any officers, members and employees thereof.

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provision of the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

IN CASE OF EMERGENCY CALL:

Name	Relationship	Phone Number

SIGNATURE OF PARENT/GUARDIAN: _____ DATE:_____

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT EXAMINATION:

Name	Phone Number	Date of Last Exam

Health Insurance Carrier	Insurance ID Number

HEALTH CONCERNS:
Does your child have any health issues that may affect their participation in this camp, such as allergies (to bee stings), medications they require, any medical conditions, any recent accidents or illness?

Explain: _____

_____

_____(Use back if needed)