CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event my child has a medical emergency while in the care/under the supervision of the Southeast Japanese School (hereinafter "Southeast Japanese School & Community Center" or "SEJSCC"), by my signature below, authorization is granted to the SEJSCC to provide emergency medical treatment. If practicable, the SEJSCC will attempt to contact parent utilizing the emergency contact information below prior to rendering treatment. It is the parent or guardian's responsibility to update emergency contact information accurately.

Child's Name: _____ Birthdate: _____
print name

Home Address: _____
_____ Phone: _____

Father's Name: _____ Phone No.: _____
print name

Mother's Name: _____ Phone No.: _____
print name

Legal Guardian's Name: _____ Phone No.: _____
If applicable, print name

Emergency Contact: _____ Phone No.: _____
print name

Relationship: _____

Family Doctor: _____ Phone No.: _____
print name

Health Insurance Company.: _____

Allergies: _____
_____

Special Instructions for Emergency Medical Services: _____
_____
_____

I hereby hold harmless the SEJSCC from any liability, claims or damages, including injuries, in connection with sanctioned activities. I understand that medical insurance is my (our) responsibility and any cost incurred for treatment shall be my (our) sole responsibility. This form shall remain in full force unless rescinded in writing.

X _____ _____
Father's Signature Date

X _____ _____
Mother's Signature Date

X _____ _____
Legal Guardian's Signature (if applicable) Date

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