**MEDICAL CONSENT AGREEMENT**

If I should require medical treatment because of injury or illness during the program, I understand that every effort will be made to contact the person for whom I have provided information below. I consent to such treatment in an emergency or if I am unable to consent to such treatment.

A copy of my medical insurance card from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is attached.

I acknowledge that my institution does not provide health and accident insurance for program participants and I agree to be financially responsible for any medical bills incurred as a result of emergency or other medical treatment. I have listed medical conditions about which emergency medical personnel should be informed below.

I acknowledge that I have read the foregoing MEDICAL CONSENT, understand it and sign it voluntarily. I am at least eighteen (18) years of age and fully competent and I fully intend to be bound by the terms of this agreement.

Printed Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Student Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of emergency contact Emergency Contact Phone Number