

# Consent & Authorization for Medical Care & Image Use

## Consent to Treatment of Adult or Minor (& Releases) for Westmont Trailhead Program

PLEASE COMPLETE A SEPARATE FORM FOR EACH PARTICIPANT. PRINT LEGIBLY.

<b>Participant</b>	Name (Last, First)	Birth Date	
<b>Medical Info</b>  LEAVE BLANK WHERE NOT APPLICABLE.  CHECK HERE <input type="checkbox"/> IF CONTINUED ON REVERSE.	Known allergies (including food, medication, environmental, etc)		
	Current medications		
	Physical restrictions		
	Previous injuries		
	Other info: a) medical for emergency assistance providers; b) behavioral to help program staff provide a good experience		
<b>Contacts</b>  PROVIDE AT LEAST ONE PHONENUMBER FOREACHPERSON. INCLUDEAREA CODE.	<b>Parent or Legal Guardian</b> (if Participant is a minor; otherwise leave this cell blank)		
	Phone/s for Participant, or Parent or Legal Guardian		
	Home	Work	Cell
	Email		
	<b>Primary Physician</b>		
	Phone/s		
	Office	Pager	Cell
	<b>Primary Dentist</b>		
	Phone/s		
	Office	Pager	Cell
<b>Authorized Relative/Friend</b>			
Phone/s			
Home	Work	Cell	
Email			
<b>Behavior Management</b>  <b>Authorization for Medical Care</b>  <b>Acceptance of Circumstances &amp; Assumption of Risk</b>  <b>Image Release</b>	I understand that: <b>a)</b> behavior which disrupts the program or poses a threat to the safety of self or others will not be tolerated; <b>b)</b> if Participant is unable to self-regulate their behavior then, after the event sponsor (or its agent) has made a good faith effort to resolve the issue (and, if Participant is a minor, sought to consult with a parent or legal guardian), Participant may be removed from the remainder of the event; and <b>c)</b> in such case there will be no refund of fees.		
	If an injury or illness requires, in the opinion of the person in charge, medical or dental examination or treatment, I authorize and direct that person (or their agent) to: a) arrange transportation by car or ambulance to the closest hospital; b) call the Medical Professional/s named above; and c) attempt to reach one or more of the other listed contacts; and/or d) apply best judgment to dispense/administer indicated medication/s. If a named Medical Professional is unavailable, I authorize any emergency treatment deemed necessary by a medical professional licensed for the required service.		
	I understand that Westmont College assumes no financial responsibility or legal liability for medical care or ambulance transportation. I also verify that the Participant is in sufficient health to be able to participate in the event identified above. I recognize that all physical activity has some risk of injury or even death and, except for any negligence, on behalf of all interested parties I release Westmont from liability for such loss.		
	I authorize the use, in future program publications, of biographical, image, video or audio content recorded for or during event activities and which includes this Participant.		
<b>Signature*</b>	Participant, or if minor, Parent or Legal Guardian	Date	

\*Electronic signatures, facsimiles, and any other electronic transmission of this signed document shall have the same legal validity and enforceability as a manually executed signature.

