Tallahassee Police Department

Y.C.P.A Emergency Contact and Medical Consent

Name_____ DOB_____

School_____Grade_____

Age_____

Medical Information

List any allergies_____

List any medications being used_____

List any current/past major conditions_____

Physician's name_____Phone_____

Persons to notify in case of emergency

Name: _____Relationship_____

Phone_____

Name_____Relationship_____

Phone_____

Consent of Parent / Legal Guardian

I hereby agree to his/her participation and waive all claims against the leaders, members, and representatives of the Y.C.P.A program and the City of Tallahassee.

In the event of any medical emergency requiring immediate medical treatment, I hereby authorize Y.C.P.A representatives to give the necessary consent for medical treatment.

Date_____Parent or Legal Guardian_____

(Signature)