

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)