Participant/Volunteer
Emergency Treatment Authorization

Student Information

Name: _____ Date: _____

Birth Date: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury, I authorize Square Peg Foundation to:

- ☐ Secure and retain medical treatment and transportation as needed.
- ☐ Release client records upon request to medical and emergency personnel.

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life-saving" or "immediately necessary" by medical or emergency personnel. This provision will ONLY be invoked if the participant/volunteer is not 18 or over, OR is otherwise unable to give consent themselves, AND the Emergency Contact named on the Participant Profile cannot be reached.

Non-Consent Alternative

I do not give consent for emergency medical aid/treatment. In the event emergency medical aid/treatment is required due to illness or injury, I wish the following procedure to take place:

_____

_____

_____

_____

_____

Consent Name (Please print clearly): _____

Consent Signature: _____ Date: _____
Participant/volunteer, Parent, or Guardian

Physician & Insurance Information

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance: _____ Policy #: _____

Insurance Service Phone: _____ Group #:_____

[See Participant/Volunteer Profile for emergency contact, allergies, and medications]

Square Peg Foundation
PO Box 29249
San Francisco, CA 94129
http://www.everyonefits.org

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