

Charles River Diving

Consent to Treatment and Emergency Information

We _____,
and _____
_____ do hereby state
that we are the natural parents and/or have legal custody
of _____
_____, age _____. We
authorize to consent to any examination, anesthetic,
X-ray, medical or surgical diagnosis or treatment and/or
hospital care to be rendered to the minor under the general
or special supervision and on the advice of any physician
or surgeon licensed to practice when efforts to contact us
are unsuccessful.

_____ date ____/____/____
(Parent or Guardian signature)

(Witness signature)

_____ date ____/____/____
(Parent or Guardian signature)

(Witness signature)

NOTARY

City/County of _____

State of _____

Acknowledged before me this ____ day of _____, 19____.

(Notary signature)

My commission expires _____, 19____.

EMERGENCY INFORMATION

I, _____
request that the following information be considered when medical
treatment is rendered to _____
_____.

Known allergies _____
_____.

Medication child is taking _____
_____.

Medical History _____
_____.

Choice of Hospital or Facility _____
_____.

Choice of Physician(s) (Include specialists)

_____.

Child's Home Address

_____ Phone(____) _____

Parents or Guardian's Address

_____ Phone(____) _____

Possible location of parent(s) or guardian(s) (use pencil)

| Location | Phone |
|-------------|--------------|
| Home _____ | (____) _____ |
| Work _____ | (____) _____ |
| Work _____ | (____) _____ |
| Other _____ | (____) _____ |

| Other Relative's Name | Relation | Phone |
|-----------------------|----------|--------------|
| _____ | _____ | (____) _____ |
| _____ | _____ | (____) _____ |

Signed _____

Date ____/____/____.