LifeAct
(formerly known as Suicide Prevention Education Alliance - SPEA)
Youth Advisory Board – Consent Form and Emergency Medical Authorization Form

DIRECTIONS: *Parent/Guardian must complete his/her part of this form for LifeAct Youth Advisory Board Member to be allowed to participate in all LifeAct and Youth Advisory Board activities*

THIS FORM REQUIRES SIGNATURES ON EACH SIDE

_____ ____/____/____ _____

Child's Name Date of Birth Age

LifeAct and Youth Advisory Board Activities

I grant permission for my child,_____ to attend all LifeAct and Youth Advisory Board related activities.

As the parent/guardian, I,_____, agree to release and hold harmless LifeAct, LifeAct, and/or LifeAct Board of Trustee members from any and all liability, loss, damages, claims or, actions for bodily injury and/or property damages in accordance with current State and Federal law, arising out of participation in any YAB or LifeAct event, meeting, or activity, including travel to and from YAB and LifeAct meetings, events and activities.

✎ _____ ____/____/____

Signature of Parent/Guardian Date

MEDICAL EMERGENCY CONTACTS + AUTHORIZATION

_____ _____ _____

(Name of Parent or Guardian) (Home #) (Cell #)

_____ _____ _____

(Name of Parent or Guardian) (Home #) (Cell #)

_____ _____ _____

(Name of OTHER emergency contact) (Home #) (Cell #)

SEE OVER

(continued from other side)

(Name of Doctor)	(Phone #)	(Hospital)
(Name of Medical Specialist)	(Phone #)	(Hospital)
(Name of Dentist)	(Phone #)	

***Either** Part I or Part II **must** be completed.*

√ **Part I (Consent for Treatment)**

I hereby given consent for the medical care providers listed within to be called. In the event reasonable attempts to contact parent(s)/guardian(s) listed above have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted are listed below:

(Signature of Parent/Guardian)	(Date)	(Address)

√ **Part II (Refusal to Consent)**

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish LifeAct to take no action or attempt to provide any medical attention.

(Signature of Parent/Guardian)	(Date)	(Address)

SEE OVER