

**Authorization for Emergency Medical Treatment**

**Your Name** (*please print legibly*)...............................................................................................................................

**Emergency Contact Person** - *In case of emergency, the following person should be contacted\*:*

Name (*please print legibly*) ...........................................................................................................................................

Relationship ........................................................................................................................................................................

Daytime Phone ............................................................. Evening Phone .....................................................................

E-mail ........................................................................................

*\* The emergency contact person should be someone who can either collect you from the MSC course or help to make transportation arrangements.*

*\* To participate in MSC, we need to have your emergency contact person’s name and contact details.*

**Prescription Medication Information**

We ask for this information so that, in the event of an emergency, we can give this form to Emergency Medical Services personnel on your behalf. Teachers will see this information and unless needed in an emergency situation, it will be kept entirely confidential.

Are you allergic to any medications? If so, please list:

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Please list your current medications and the conditions being treated.

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