WEST HILLS COLLEGE
LEMOORE

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Emergency Treatment Consent

I, _____, give my permission and consent for emergency treatment, in the event of an accident or sudden illness, by the staff of any and all hospitals while using the clinical facilities of a specific hospital as assigned by the WHCL Health Careers Office while a student of WHCL.

I DO ____ or **I DO NOT** ____ give my permission for the administration of blood when prescribed by a physician.

_____ _____ _____

Student Signature WHCC ID# Date

IN CASE OF EMERGENCY, contact the following:

Name_____ **Name**_____

Relationship_____ **Relationship**_____

Phone-residence _____ **Phone-residence** _____

Phone-cell _____ **Phone-cell** _____