



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 _____