



# EMERGENCY TREATMENT CONSENT FORM

I affirm I am the parent and/or legal guardian of \_\_\_\_\_  
NAME OF MINOR  
 parent/guardian, I hereby authorize Soda City Divers LLC dba Columbia Scuba, and/or its agents,  
(DIVE CENTER/RESORT/INSTRUCTOR)  
 employees or assigns, to seek medical treatment for \_\_\_\_\_,  
(MINOR)  
 of an accident or illness while under the supervision of \_\_\_\_\_  
(DIVE CENTER/RESORT/INSTRUCTOR)

I affirm I have read the **Certificate of Understanding and Express Assumption of Risk** form, signed it of my own free will, and understand the legal consequences of signing the document.

I authorize the treatment of \_\_\_\_\_,  
(MINOR)  
 licensed physician in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed.

I have fully informed myself of the contents of this **Emergency Treatment Consent Form** by reading it before I signed it.

PARENT/GUARDIAN (please print)	DATE
SIGNATURE OF PARENT/GUARDIAN	HOME PHONE
ADDRESS	WORK PHONE

Specific medical allergies, medicine being taken or other conditions physician should be aware of (if none, please write NONE):  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_