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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 Lemoore College (LC) Health Careers Office while a student of LC.

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

____________________________________ ____________________ ________________

Student Signature LC student ID# Date

IN CASE OF EMERGENCY, contact the following:

Name____________________________	**Name** ______________________________
Relationship______________________	**Relationship** ________________________
Phone-residence___________________	**Phone-residence** _____________________
Phone-cell _______________________	**Phone-cell** __________________________

Lemoore College Health Careers Office Contact Information
Room 823
559-925-3490
healthcareerslemoore@whccd.edu