UNIVERSITY OF HAWAI'I • KAPI'OLANI COMMUNITY COLLEGE

Nursing Department

<u>MEDICAL CONSENT FORM</u>
(To be completed by student or parent if a minor)

Please Fill out either A **OR** B:

A.   I (We) _____ consent to and
       <div align="center">(student or parents/guardian if a minor)</div>

authorize any medical doctor or dentist and others working under their supervision to treat

_____ _____ for any illness or injury.
<div align="center">(name of participant)</div>

I (We) further agree to pay any and all such dental and medical costs, expenses, and charges and to release and discharge and hold harmless the State of Hawai'i, its employees and agents from and against any liability or any claim or demand arising from or connected with such medical treatment or care.

<div align="center">*************OR**********</div>

B.   I (We) _____, <u>DO NOT</u> consent to
       <div align="center">(student or parents/guardian if minor)</div>

or authorize any medical doctor or dentist or others working under their supervision
to treat _____ _____ for any illness or injury.
<div align="center">(name of participant)</div>

I (We) therefore agree to assume the risk of any injury or damages relating to, and outside of or in connection with said failure to provide any medical treatment or care.

I (We) therefore agree to assume the risk of any injury or damages to
_____ _____ from the lack of any medical care or treatment
<div align="center">(name of participant)</div>
and further agree to release and discharge and hold harmless the State of Hawai'i, its employees and agents from and against any liability and any claim or demand arising out of or in connection with said failure to provide any medical care and treatment.

_____	_____
Student's Signature	Date
_____	_____
Co-signature of parent or guardian if a minor	Date
_____	_____
Home Address	Phone (Home)
_____	_____
City Zip Code	Phone (Business)

1.   IN CASE OF EMERGENCY NOTIFY: <u>Please</u> <u>Give</u> <u>at</u> <u>least</u> <u>two</u> <u>names</u>:

First   _____   Phone _____
Second   _____   Phone _____
Third   _____   Phone _____

Give name of physician. If you don't know, write "NA".
2.   PHYSICIAN'S FULL NAME _____ Phone _____
Are you under treatment for any condition or taking any medications we should know about? Please specify.