



Brian Kay, Director • **Tami Letcavage**, Assistant Director • **Emily Minna**, Recreation Coordinator
Kathy Edwards, Account Clerk

CHARTER TOWNSHIP OF CLINTON
MACOMB COUNTY, MICHIGAN

PARENTAL/GUARDIAN CONSENT AGREEMENT for EMERGENCY MEDICAL CARE
ASSUMPTION OF RISK/WAIVER OF LIABILITY/INDEMNIFICATION

The party executing this Parental/Guardian Consent Agreement (“Agreement”) warrants and represents that they are the appropriate party or parties who have authority to grant approval for the provision of emergency medical care on behalf of the participants listed below.

An individual, who requires specific emergency medical care treatment, must provide a written Emergency Medical Care Plan with a copy of any prescription and/or statement from the current treating physician which clearly contains specific instructions of the type and manner of care to be furnished. This Emergency Medical Care Plan must be dated and also signed by a physician, and updated annually. It is the responsibility of the parent/guardian to update the Emergency Medical Care Plan whenever there is a change in that plan.

To the extent the participant is able to furnish care themselves such course of action will be the first choice, where appropriate. Should assistance be necessary, the undersigned parents/guardians assume the risk associated with the administration of medical care. The undersigned understands that the Township personnel do not have instruction in the administration of specific emergency medical care other than basic Red Cross Training and any Emergency Medical Care Plan information furnished, in writing, by the physician.

To the extent permitted by law, the undersigned waive and release the Township, its employees and agents of any liability directly or indirectly associated with the delivery of emergency medical care.

Further, the undersigned agree to indemnify and hold harmless the Township, its employees and agents from any claims associated with the delivery of emergency medical care to the extent allowed by law.

*Print participant's name: _____
(*A separate form is needed for each healthcare challenged person.)

Parents/Guardians:

Print Name: _____

Signature: _____

Date: _____ Phone #: _____

Print Name: _____

Signature: _____

Date: _____ Phone #: _____

OFFICE USE ONLY

Date /Initial

_____/_____

Emergency Medical Care Plan received (including date, Physicians signature and contact information, prescription and/or clear written explanation).

_____/_____

Proof of legal decision making rights (court document such as divorce decree/judgment, guardianship document, death certificate, etc.) if two signatures are not entered above.