CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328.

San Mateo County Health System
Behavioral Health and Recovery Services

Emergency/Medication Consent Release Form

Youth's Name _____ **DOB** _____

Address _____

Parent or Legal Guardian _____

Home # _____ *Work #* _____ *Pager #* _____

Emergency Contact _____

Home # _____ *Work #* _____ *Pager #* _____

Medical Doctor _____ *Office #* _____

Dentist _____ *Office #* _____

Medi-Cal # _____ **Other Insurance** _____ #_____

Allergies: **Food** _____

Medicine _____

Other _____

Daily Medication: **Yes** _____ **No** _____

If Yes, Drug _____ **Dosage** _____ **Time/s** _____

Prescribing MD: _____ **Prescription #** _____

Drug _____ **Dosage** _____ **Time/s** _____

Prescribing MD: _____ **Prescription #** _____

Drug _____ **Dosage** _____ **Time/s** _____

Prescribing MD: _____ **Prescription #** _____

List any medical condition limiting the youth from participating in any activity.

_____

_____

I, the undersigned, authorize _____ to administer above medication as prescribed to _____ (youth) and consent to emergency medical treatment for _____ (youth) as deemed necessary and or advisable in the judgment of _____ and/or the examining physician in the event I can not be located at the time of said emergency.

Signature of parent/legal guardian _____ Date _____