# Emergency Contact Information and Consent-to-Treat Form

**U.S.-Philippines Research Experience for Undergraduates (REU)**
**Department of Biological Sciences**
**Old Dominion University**

Participant's Name: _____

Date of Birth: _____ (mm/dd/yy)

Participant's Home Address: _____

_____

Participant's Home Phone: _____

**Participant's Emergency Contact Information:**

In emergency, please contact: _____

Relationship: _____

Home Phone/Fax: _____

Work Phone/Fax: _____

Alternate Contact: _____

Relationship: _____

Home Phone/Fax: _____

Work Phone/Fax: _____

Personal Physician: _____

Phone/Fax: _____

Medical Insurance (include both domestic and international policies, as appropriate):

Carrier: _____

ID #: _____

Carrier: _____

ID #: _____

Personal Dentist: _____

Phone/Fax: _____

**Consent to Treat:**

I, the undersigned participant in the U.S.-Philippines REU Program, if I am unconscious or incapacitated, do consent to emergency medical treatment as recommended by a physician during my participation in the Program. Additionally, I give my permission for Program administrative staff to authorize appropriate emergency medical treatment as recommended by a physician during my participation in the Program. This authorization shall continue in force until the conclusion of the Program.

_____ _____

Participant's Signature Date

If the participant is under twenty-one (21) years of age, a parent or legal guardian through signature below must also give their permission for emergency medical treatment under the above conditions.

_____ _____

Parent's/Guardian's Signature Date

_____

Parent's/Guardian's Name (printed)

OR

☐ (check box) I refuse to give my consent to emergency medical treatment as recommended by a physician during my participation in the Program. Furthermore, I refuse to give my permission for Program administrative staff to authorize appropriate emergency medical treatment.

_____ _____

Participant's Signature Date

If the participant is under twenty-one (21) years of age, a parent or legal guardian through signature below must also refuse their permission to treat the participant in the event of a health or medical emergency.

_____ _____

Parent's/Guardian's Signature Date

_____

Parent's/Guardian's Name (printed)