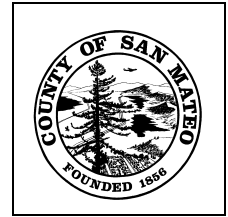


**CONFIDENTIAL
PATIENT
INFORMATION:
See California
Welfare and
Institutions Code
Section 5328.**

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 _____