

**UNIVERSITY OF HAWAII AT MĀNOA**

School of Hawaiian, Asian and Pacific Studies

**MEDICAL CONSENT FORM**

**IMPORTANT: READ CAREFULLY (TO BE FILLED OUT BY THE UNIVERSITY HEALTH CENTER OR A PHYSICIAN)**

Is \_\_\_\_\_ physically fit for fieldtrips to temples, bus excursions, exposure to sunlight, etc.  
yes no

If No, please explain in detail:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**IN CASE OF EMERGENCY:**

First person to contact is: \_\_\_\_\_

Phone: \_\_\_\_\_

Second person to contact is: \_\_\_\_\_

Phone: \_\_\_\_\_

Third person to contact is: \_\_\_\_\_

Phone: \_\_\_\_\_

**PLEASE CHECK AND FILL OUT ONE OF THE FOLLOWING:**

We (I), \_\_\_\_\_, consent to and authorize any medical doctor  
(Name of Parents/Guardian)  
or dentist and others working under their supervision to treat \_\_\_\_\_ for any injury  
or illness. (Participant's Full Name)

We (I) 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 Hawaii, its employees and agents from and against any liability or any claim or demand arising from or connected with such medical treatment or care.

We (I), \_\_\_\_\_, do not consent to or authorize any medical doctor or  
(Name of Parents/Guardian)  
dentist or others working under their supervision to treat \_\_\_\_\_  
for any injury or illness. (Participant's Full Name)

We (I) therefore agree to assume the risk of injury or damage to \_\_\_\_\_  
(Participant's Full Name)

from lack of any medical care or treatment and further agree to release and discharge and hold harmless the State of Hawaii, 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 or treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

**U N I V E R S I T Y   O F   H A W A I ' I   A T   M Ā N O A**

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Co-signature of Parent/Guardian