

STONE LABORATORY

The Ohio State University's Island Campus on Lake Erie

2008 MEDICAL CONSENT FORM

I give my consent for any medical treatment that I/or my child, (please print name of program participant)

_____, might require while in the Stone Lab program during the period of _____ to

_____. I authorize and request The Ohio State University Stone Laboratory personnel to refer me/or my child to duly licensed medical authority when indicated, including transfer to hospitals. I hereby grant authority to a qualified physician to render such medical treatment as the physician deems necessary under the circumstances. I have medical coverage for myself or my child through,

Company Name: _____.

In the event of an emergency, please contact: Name _____ Phone# (_____) _____ or

Name _____ Phone# (_____) _____. My/ or my child's regular physician is

Dr. _____ Address: _____

and can be reached at Phone# (_____) _____.

If the participant is under age 18, a parent or legal guardian must sign this form.

PARTICIPANT'S FULL NAME (Please print) _____

PARTICIPANT'S SIGNATURE _____

PARENT OR LEGAL GUARDIAN'S FULL NAME (Please print) _____

PARENT OR LEGAL GUARDIAN'S SIGNATURE _____