

**HOUSE OF POSSIBILITIES, INC.**  
350 Washington Street, North Easton, MA 02356  
Tel 508-205-0555 – Fax 208-205-0557

**Statement of Consent to Medical Personnel**

In the event of an emergency or non-emergency situation requiring medical treatment, I,  
\_\_\_\_\_, hereby grant House of Possibilities, Inc. ("HOPE")

(name and address)

permission for any and all necessary medical to be administered  
to \_\_\_\_\_ in the event \_\_\_\_\_

(name of child participant)

experiences an accidental injury or illness, while participating in the House of Possibilities program, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, etc. under the recommendation of qualified medical personnel.

Name of Parent / Guardian: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_

Telephone number(s) to call in Emergency: \_\_\_\_\_

\_\_\_\_\_

**NOTE: The House of Possibilities, Inc. requires a copy of a parent's current Driver's License or a copy of the Court Order appointing the Guardian with this Consent Form.**

- Copy of Driver's License provided
- Copy of Court Order appointing Guardian provided

Date: \_\_\_\_\_

If I can not be contacted at the telephone numbers I provided, I authorize HOPE to contact the following individuals who have my authorization to address any medical emergency involving \_\_\_\_\_

(name of child participant)