# RIGHT OF REFUSAL OF MEDICAL AID

**Show Name:** _____

I hereby refuse the first aid treatment recommended to me by the First Aid Person employed by my production for the illness or injury incurred by me on this date.

In signing this waiver, I release the First Aid Person, the Production and its personnel from any liability resulting from this refusal to accept such first aid treatment.

_____ _____
Injured's or Guardian's Signature Date

_____/_____ _____
Injured's Name (print) Injured's Cell # Job Title or Position

_____ _____
Guardian's Name in case of minor Relationship to Injured

_____
First Aid Person Signature

_____
First Aid Person Name (print)

_____
Witness Signature

_____/_____
Witness Name (print) Witness Cell #

This form should be signed, dated and returned to the Production Safety Representative.

**NOTES:** _____

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