MEDICAL TREATMENT AUTHORIZATION AND CONSENT

I, _________________________________, parent or legal guardian of _______________________________ _______, a minor child (hereafter the "Child") hereby grant my authorization and consent for _ ___________________________________ (hereafter the "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Child. If the injury or illness is life threatening or in need of emergency treatment or doctor examination and opinion, I authorize Designated Adult to seek any and all professional services, emergency personnel to attend, transport and treat the Child, and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under, the general supervision of, any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice medicine in the state in which the treatment is to occur.

Child's Information:

Full Name: _________________________________ Date of Birth: _______________________

Address:___________________________________ Age: _____________________________

____

Parents' Information:

Parent 1: __________________________________ Phone Number: ____________________________

Address:__________________________________ Alternate: ____________________________

____

Parent 2: __________________________________ Phone Number: ____________________________

Address:__________________________________ Alternate: ____________________________

____

Insurance Information:

Insurance Company: ________________________ Policy Holder: ______________________________

Policy/Group#: _____________________________

Medical Information:

Doctor: ____________________________________ Phone Number: ____________________________

Dentist: ___________________________________ Phone Number: ____________________________

Allergies to medications: ____

Medications currently taking: ____

Any conditions for which Child is currently receiving treatment: ____________________________________
____

Any significant medical information or allergies: ____
____

Parent 1 signature: ____ Date: ________________

Parent 1 printed name: ____________________________________

Parent 2 signature: ____ Date:_________________

Parent 2 printed name: ____________________________________