AUTHORIZATION FOR TREATMENT

To whom it may concern:

This document is to be used for AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT for the child listed below.

Name _____ Sex ___ Birthdate _____ / ____ / _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Emergency Phone _____

Parents (Legal Guardians) Names _____

Address (If Different) _____

Insurance Company _____ ID# _____

Doctor _____ Phone # _____

Any allergies or past or present medical problems? Yes _____ No _____
(If yes, please explain on back)

THIS DOCUMENT GIVES CONSENT TO ANY HOSPITAL OR EMERGENCY TREATMENT CENTER, DOCTOR OF QUALIFIED EMPLOYEES OF THE SAME TO ADMINISTER NECESSARY TREATMENT AND CARE. IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN, SELECTED BY THE ADULT LEADER IN CHARGE, TO HOSPITALIZE, SECURE PROPER ANESTHESIA, OR TO ORDER INJECTION OR SURGERY FOR MY CHILD.

Parent / Guardian Signature _____ Date _____

Witness _____

THIS FORM IS TO BE RETURNED TO YOUR CHILD'S COACH.