



*Please complete this form and return it to your teacher.*

Participant's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### EMERGENCY INFORMATION

Father's Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Allergies \_\_\_\_\_ Date of last Tetanus booster \_\_\_\_\_

Other medical conditions or concerns \_\_\_\_\_

Current medication(s) being taken (include dosage/frequency) \_\_\_\_\_

Present state of health \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

### AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, understand and acknowledge that every effort will be made to contact the parents/guardians in case of an emergency, and, if possible, before any medical treatment is administered. In the event of an emergency or if the parents/guardians cannot be notified, I hereby give permission to secure proper treatment for my child as named on this form. If necessary, this includes selection of physicians and medical treatment facility who are then authorized to perform such medical treatments as deemed necessary to protect the health of my child.

In the event of any emergencies during the trip, the undersigned hereby grants authority to be exercised at the discretion of the program leader or chaperone to dispense over-the-counter medication.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_