Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be given to the trip leader or shown to the trip leader and then carried by the designated adult.

Minor	
Full Legal Name:	
Home Address:	
Date of Birth:	Gender: FemaleMale
Information for Medical Treatment	
Physician's Name and Location of Practice:	
Physician's Phone # (if known): ()	
Medical Insurer/Health Plan:	Policy #:
Allergies to Medications:	
Allergies (Other):	
Please note all conditions for which the chil	d is currently receiving treatment:
Note any other significant medical informat	ion:
	SENT OF PARENT(S) OR LEGAL GUARDIAN(S) f the aforementioned Minor. I grant my authorization and
consent for	(hereafter "Designated Adult") to
injury or illness is life threatening or in need summon any and all professional emergency consent for any X-ray, anesthetic, blood train hospital care deemed advisable by, and to be physician, surgeon, dentist, hospital, or other	y minor injuries or illnesses experienced by the Minor. If the dof emergency treatment, I authorize the Designated Adult to y personnel to attend, transport, and treat the minor and to issue asfusion, medication, or other medical diagnosis, treatment, or the rendered under the general supervision of, any licensed or medical professional or institution duly licensed to practice it. I agree to assume financial responsibility for all expenses of
	en in advance of any such medical treatment, but is given to he Designated Adult in the exercise of his or her best judgmen rgency personnel.
This authorization is effective through:	Signed thisday of, 20
Parent / Legal Guardian Signature:	Printed Name:
Witness Signature:	Printed Name: