

MEDICAL TREATMENT AUTHORIZATION
FOR PARTICIPATING MINOR, 14 – 18yrs

(Must be accompanied by Volunteer Release form signed by parent)

Name of minor: _____

I represent and warrant to Rebuilding Together * Portland that I am the parent or legal guardian of the minor named above. The above named minor has my permission to participate in the Rebuilding Together Portland project (the "Project") currently scheduled for _____, 2009. **On behalf of such minor and myself, I have signed a Volunteer's Agreement and Release from Liability** (the "Release") and hereby agree to all of the terms and conditions of the Release.

In case of medical or dental emergency, I request that Rebuilding Together * Portland attempt to contact me at the telephone number set forth below. However, I hereby give permission to the physician or dentist selected by Rebuilding Together * Portland to hospitalize, treat, secure proper treatment for, and order injections, anesthesia or surgery for the minor named above. A copy of this permission form may be accepted by and treated by the physician or dentist as equivalent to the original permission form.

_____ Date	_____ Signature of Parent/Guardian	_____ Telephone
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PLEASE COMPLETE THE FOLLOWING:

1. Medical Insurance Carrier: _____
Policy Number: _____
2. Family Doctor: _____
Address: _____
Telephone: _____
3. Family Dentist/Orthodontist: _____
Address: _____
Telephone: _____
4. Any drug or food allergies: _____
5. Limitation on activities: _____

6. If cannot be reached, please contact: _____
Telephone: _____