AUTHORIZATION FOR MEDICAL CARE

I,_____ the undersigned parent or person having legal custody or the legal guardian of _____ do herby authorize the chaperoning educator or leader to consent to any x-ray examination, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of each respective state.

In giving this consent I recognize and understand that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgably evaluated and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to forgoing all treatment, in such situations, I authorized a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment as he in his professional judgment determines to be necessary for the health and safety of the above named minor.

In giving this consent I recognize and understand that every precaution will be taken to safeguard the health and welfare of all who attend, however, in consideration of allowing said child to attend and participate in this activity, I, as a parent or legal guardian of the individual, do hereby release all participants, sponsors and leaders from any claim from injury sustained to person or property of said individual.

Parent/Guardian Information

Work Phone _____ Home Phone _____
Address _____ County _____
City _____ State _____ Zip Code_____
Student's Social Security # _____
Father's Social Security # _____
Mother's Social Security # _____
Family Medical Insurance Company _____
Policy Number _____

Treatment Information

Student's Birth Date _____ Sex _____
Student's Allergies _____
_____
Family Doctor _____ Phone _____
Other Doctor _____ Phone _____
Medicine student is taking _____
_____
Date of Student's last Tetanus Shot _____
Delegate's Medical History (diabetes, asthma, etc.)_____
_____

If the student has a serious medical condition or is under a doctor's care, a letter from the doctor should be attached outlining the nature of the condition, treatment or medical history.

Signature _____ Date _____
(of a person or person having legal custody or legal guardian)