MEDICAL TREATMENT AUTHORIZATION FORM

Name of Child (please print) _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Print the names of parent(s) and/or legal guardian(s):

_____

Name of Program to be attended _____

Medical History

1. Does the child have any known physical defect or illness which might interfere with his/her participation in strenuous activity? If so, please explain.

2. Does the child have any allergies or reactions to drugs or medicines? Explain.

3. Does the child have any other allergies? Explain.

4. Is the child presently taking any medications or on any special diet or exercise restrictions? If yes, please list specific details (name of drugs, dosage, etc.).

5. Indicate the date of last TTB (Tetanus, Dip Tox, Booster shot) _____

6. Are there any emotional/social disabilities that would be helpful for us to be aware of?

7. Is your son/daughter living with ___ both parents ___ one parent ___ guardian ___ other

Health Insurance Information

Policy Holder's Name _____

Insurance Company _____

Policy Number _____ Phone Number _____

Medical Doctor _____ Phone Number _____

Emergency Contacts

Name of persons and telephone numbers to call in case of emergency:

Parent/Guardian _____ Home_____ Work_____ Cell _____

Parent/Guardian _____ Home_____ Work_____ Cell _____

Other _____ Home_____ Work_____ Cell _____

Other Information

Other information leaders should know about the child participant:

_____

_____

First Aid and Emergency Medical Treatment

I recognize that there may be occasions where the child named above may be in need of first aid or emergency medical treatment as a result of an accident, illness, or other health condition or injury. I do hereby give permission for agents of this program to seek and secure any needed medical attention or treatment for the child named above including hospitalization, if in the agent's opinion such need arises. In doing so, I agree to pay all fees and costs arising from this action to obtain medical treatment.

I give permission for attending physician(s) and other medical personnel to administer any needed medical treatment, including surgery and, again, I agree to pay for the medical treatment.

I give permission to transport the child named above to a medical treatment center in a non-emergency vehicle in a medical emergency situation.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Name of Parent or Legal Guardian

_____ _____

Witness Signature Date