----------MEDICAL AUTHORIZATION FORM ----------

Purpose: to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured if parents or guardians are not available.

Participant Name: _____ Participant Birthdate: _____

Parent Name: _____ Phone Number: _____

Additional Emergency Contacts:

CONTACT ONE:

Name: _____ Phone Number: _____

Relationship: _____

CONTACT TWO:

Name: _____ Phone Number: _____

Relationship: _____

IF PARENT CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

_____

Primary Physician:

Name: _____ Phone Number: _____

Address: _____

Medical Insurance Information:

Group Name/Plan # _____

Name of insured (or person responsible for payment) _____

Allergies (including food allergies) or Other Medical Limitations:

_____

_____

Permission for Medical Treatment:

Administrative procedures vary among medical personal and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance. In case of an emergency or accident, I authorize my child's caregiver or other authorized adults to take my child to the above named physician or to the nearest hospital for emergency treatment. I authorize the administration of measures as are deemed necessary for the safety and protection of the child.

Parent's Signature: _____ **Date:** _____