

MEDICAL CONSENT AND PERMISSION TO TREAT

Name: _____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

Father / Guardian: _____ Daytime Phone: _____

Mother / Guardian: _____ Daytime Phone: _____

Address: _____ Home Phone: _____

Other Contact Person: _____ Phone: _____

Please list a contact who is not a member of your household who can be notified of an emergency in case the parents cannot be reached

PRIMARY CARE INFORMATION

Dr. _____ Doctor's phone # (____) _____

Insurance Carrier _____

Policy Holder _____ Policy # _____

Date of Last Tetanus Immunization: _____

ALLERGIES AND OTHER HEALTH CONDITIONS

Please list any medical condition(s), such as recent surgeries, asthma or non-seasonal allergies that leaders need to be aware of while your child participates in this event. Also list any major illnesses your child has had in the past six months.

Please list any disabilities or physical/mental conditions that may affect your child's participation as well as suggestions for adapting activities to be more inclusive if necessary:

Please check if your son/daughter is taking medication. Please bring medication in the original prescription container with the label still attached. All medication must be monitored by an adult. Directions for taking medication, including frequency, dosage and storage are as follows:

Please check if you grant permission for non-prescription medication such as cough drops, Tylenol, etc. to be given to your child if necessary. Preferences:

In the event of an emergency, I hereby give permission to transport my child to a qualified health care facility for emergency medical or surgical treatment and authorize the release of medical records to qualified physicians for the treatment. I understand that I will be promptly notified in the event any illness or accident requires professional medical care and prior to any surgery except when delay in such communication would endanger life. In the event that I cannot be reached, I hereby give permission to the physicians selected by the leaders of the event my child is participating in to hospitalize, secure proper treatment for, and to order tests, therapies, or surgery if deemed necessary for my child.

Parent/Guardian Signature: _____ Date: _____

PLEASE INCLUDE A COPY OF INSURANCE CARD (front and back)