Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be in the possession of the event leader or designated adult.

Minor

Full Legal Name: ______________________________

Home Address: ______________________________

Date of Birth: ______________________________ Gender: Female ________ Male ________

Mother's Name: ______________________________ Home or Cell Number: ______________

Father's Name: ______________________________ Home or Cell Number: ______________

Emergency Contact: (If parent is not available) ______________ Phone: ______________

Parent e-mail address(es): ______________________________

Information for Medical Treatment

Physician's Name and Location of Practice: ______________________________

Physician's Phone Number: ______________________________

Medical Insurer/Health Plan: ______________________________ Policy Number: ______________

Allergies to Medications: ______________________________

Medications*: ______________________________

Please note all conditions for which the child is currently receiving treatment: ______________

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Note any other significant medical information or allergies: ______________

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*Prescription medication MUST be in pharmacy labeled containers.

Please note all conditions for which the child is currently receiving treatment: ______________

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Note any other significant medical information or allergies: ______________

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