Consent for Medical Treatment (minors only)

I, _____ , am the parent or legal guardian of _____

and I authorize (name of program) _____ to obtain emergency medical treatment of this minor by an appropriate health care professional should the need arise while he/she is attending the program.

Signature _____ Date _____

Medical Information (all participants)

Participant's name _____

Age _____ Birthdate _____ Date of last Tetanus Toxoid _____

Past health/injuries _____ Present health _____

_____ Allergic reactions _____

_____ Present medication _____

☐ Check here if the participant has special needs and might require accommodations to fully participate in the program. A staff member will contact the parent or guardian for details.

Other information that would be useful in the event medical treatment is necessary: _____

Insurance Information (all participants)

Parents or legal guardians are responsible for the cost of a minor's medical treatment. When available, insurance information will be processed by the health facility performing the treatment, otherwise you will be contacted for payment by cash, check or credit card.

Insurance company _____ Address _____

City/State/Zip _____

Policyholder's name _____

Policy number _____

Contact People (all participants)

In an emergency, parents or legal guardians can be reached as follows:

Name _____ Relationship to minor _____

Address _____ Daytime phone _____

City/State/Zip _____ Evening phone _____

Cell phone _____

Name _____ Relationship to minor _____

Address _____ Daytime phone _____

City/State/Zip _____ Evening phone _____

Cell phone _____

If other information would be helpful in contacting you, please indicate:

_____