

AUTHORIZATION for medical treatment of minors

If your child needs medical, dental, health or hospital services, under law, you as a parent must give permission. Naturally, if you are with your child you can give permission as the need arises. You can prepare for those unexpected times when you are not with your child by filling out this authorization form. Using this form, you can give permission to other adults to act for you, in your absence, regarding the treatment of your child. This is a legal document. After you complete this form, give a copy to each adult you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult should present this document to the appropriate person -- physician, dentist, or hospital representative.

When a true emergency exists a child may be treated without parental consent. This will happen when a physician determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

PLEASE COMPLETE ALL SECTIONS

A. IDENTIFICATION

Name of Minor _____

Date of Birth _____

B. ALLERGIES

My child has the following allergies or medical conditions (if none, write NONE): _____

If your child has allergies, indicate if your child ☐ does or ☐ does not have an allergic reaction kit for any of the listed allergies. If your child does, attach specific instructions to this form and indicate whether the child or the coach/chaperone will keep the kit.

C. MEDICATIONS, INCLUDING INHALERS

Medication

Medication Dosage (amount and frequency)

<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter Name: _____	_____
<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter Name: _____	_____
<input type="checkbox"/> Prescription <input type="checkbox"/> Over-the-Counter Name: _____	_____

My child uses inhalers as described above for respiratory ailments, and ☐ does or ☐ does not have my permission to keep this with him/her. If your child does not, then the coach/chaperone will keep it with him or her.

D. HEALTH CONDITIONS

Describe any health conditions or other health information that would help us treat your child in your absence:

Emergency contact name if parents are unavailable: _____ Phone# _____

Insurance Co. or Gov. Program ID/Contract# _____

Name of Ins. Plan _____ Physician's Name _____

Physician's Phone# _____ Address _____

I, being the parent, custodian or legal guardian of the above named minor, do hereby appoint the Club President, Head Coach or designated parent chaperone, to act on my behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor in my absence.

Printed Name _____ Signature _____ Date _____

Phone(H) _____ Work) _____ (Cell) _____

Street Address _____ City _____ State _____ Zip _____

Form valid for a period of one year from date signed