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: _____

_____

Note any other significant medical information or allergies: _____

_____

*Prescription medication MUST be in pharmacy labeled containers.

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

_____

Note any other significant medical information or allergies: _____

_____