

## 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 \_\_\_\_\_

*(Identification number, benefit code, account number, etc.)*

## 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:

\_\_\_\_\_