Medical Treatment Permission Form

Event_____ Date Range_____

Name:_____ Grade:_____Age _____

Best Contact Information:_____

To be completed by parent/guardian:

I give permission for necessary medical treatment for the minor named above during travel time and participation in the event named above on the date(s) listed above. (Please attach relevant insurance information.)

_____ _____
(signature) (Insurance Company)

_____ _____
(Parent/Guardian Contact) (Insurance Numbers)

Regular Doctor: _____Phone: _____
Doctor's Address: .....
Family Dentist: _____Phone:_____
Dentist's Address: .....

Present Medications: .....

Note (circle) which medications need to be protected by an adult leader.

Known Allergies: (food or environment) _____

Anything else of which we may need to be aware: _____

_____

_____

_____

_____