

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

**Please attach a copy of insurance card(s) and any other required ID**

Minor's Full Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

**Parent(s)/Legal Guardian(s) Info:**

**Parent/Guardian #1**

Name: \_\_\_\_\_  
Full Legal Name (First, Middle Initial, Last)

Relationship to minor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

**Parent/Guardian #2**

Name: \_\_\_\_\_  
Full Legal Name (First, Middle Initial, Last)

Relationship to minor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Doctor's Information:**

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Office Phone: \_\_\_\_\_

**Health Plan Information:**

Medical Insurer/Health Plan: \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_  
Full Legal Name (First Name, Middle Initial, Last Name)

Insured's Birth Date: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

**Secondary Health Plan Information:**

Medical Insurer/Health Plan: \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_  
Full Legal Name (First Name, Middle Initial, Last Name)

Insured's Birth Date: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

**Allergies to Medications:** \_\_\_\_\_

**Other Allergies** \_\_\_\_\_

If applicable please note the conditions for which the child is currently receiving treatment:

\_\_\_\_\_

Note any other significant medical information: \_\_\_\_\_

Names of Medications, doses and amount taken:

**Dentist's Information:**

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**Dental Insurance Plan**

Insurer/Health Plan: \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_  
Full Legal Name (First Name, Middle Initial, Last Name)

**Authorization and Consent for Treatment**

I grant my authorization and consent for **Helping Hands Mission Camp** (hereafter Supervising Adult) to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat my child and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

\_\_\_\_\_ Date: \_\_\_\_\_  
Legal Guardian's Signature

**Don't forget to attach copy of insurance card(s) and other required ID**