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: ______________________________

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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