*Instructions: Prepare one of these forms for EACH of your minor children, and have each form notarized.*

# Child’s Full Legal Name:

Child’s Date of Birth: \_ Age: Gender:

Child’s Allergies to Medications:

Child’s Other Allergies:

Child’s Blood type (if known)

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

Note any other significant medical information:

# Parent(s)/Legal Guardian(s):

**Parent #1:**

Name: Address:

Home phone: Cell phone:

Work phone: Pager:

Email: Additional Contact Information:

# Parent #2:

Name: Address:

Home phone: Cell phone:

Work phone: Pager:

Email: Additional Contact Information:

# Child’s Primary Physician

Doctor’s Name:

Doctor’s Address:

Doctor’s Office Phone: \_ Doctor’s Emergency Phone:

Medical Insurer/Health Plan: Policy #: Insurer/Health Plan’s phone number:

# Child’s Dentist

Dentist’s Name:

Dentist’s Address:

Dentist’s Office Phone: Dentist’s Emergency Phone:

Dentist’s Insurer/Health Plan: Policy #:

# Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: Address:

Home phone: Cell phone:

Work phone: Pager:

Email: Additional Contact Information:

# AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for (hereafter “Supervising Adult(s)”) 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(s) to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any

X-ray, anesthetic, blood transfusion, medication, operation, 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(s) in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Parents/guardians will hold the Supervising Adult(s) harmless and protect them from lawsuits, if any, arising out of the custodian's actions in caring for the child as long as the Supervising Adult(s) exercise their "best efforts" and are not guilty of intentional wrongdoing or gross negligence.

Furthermore, any medical expenses incurred in treating the minor can be filed with the above insurance company. Any amount not covered by insurance will be the responsibility of the parents/guardians.

This authorization is effective commencing on the day of , 20 and expiring on the day of , 20 .

Signed this day of , 20 .

Parent/Legal Guardian #1’s Signature

Parent/Legal Guardian #2’s Signature

# CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF COUNTY OF

This document was acknowledged before me on \_ [date] by [name of principal].

*[Notary Seal, if any]:*

(Signature of Notarial Officer)

Notary Public for the State of

My commission expires: