



CONSENT FOR MEDICAL TREATMENT OF MINORS AUTHORIZATION FORM

Authorization & Consent of Parent(s) or Legal Guardian(s) I, _____, am the parent or legal guardian of _____, a Camper. I hereby give my consent and authorization for medical care rendered to the Camper, including emergency and non-emergency diagnostic procedures and surgical and dental care. I further voluntarily consent to and authorize to administer treatment for any basic injuries or illnesses experienced by the Camper. If the injuries or illnesses experienced are more serious, I consent to and authorize the FLAG Camp staff to take appropriate measures, including summoning emergency medical personnel and the authority to issue consent for necessary medical care as deemed by 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. This includes any X-ray, anesthetic, blood transfusion, medication, or any other medical treatment. In making medical decisions on my behalf for the benefit of my camper, I direct the FLAG Camp Staff to attempt to contact me. Additionally, I authorize the health care provider to discuss in full with the FLAG Camp staff any medical information that is required to help the treatment of the Camper. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of the Camper and that I assume financial responsibility for such medical care. It is understood that this authorization is given in advance of any such medical treatment, but it is given to provide authority and power on the part of the FLAG Camp staff in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed, this ____ day of _____, 20__

This authorization is effective through ___ / ___ / ___

Printed Name of Parent/Legal Guardian

Printed Name of Witness

Signature of Parent/Legal Guardian

Signature of Witness

Primary Phone of Parent/Legal Guardian

Work Phone of Parent/Legal Guardian

Minor’s Pertinent Health Information

Minor’s Full Legal Name

Medications

Minor’s Date of Birth

Home Address

Allergies

City, State ZIP

Health Insurance Carrier

Date of Last Tetanus Shot

Health Insurance Policy # & Group #

Other Pertinent Medical History