

## **MEDICAL TREATMENT AUTHORIZATION FORM**

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

This form should be emailed or mailed to Joe Grosek at Joe Grosek, P.O. Box 69. Rutledge, TN 37861 or [jgrosek@glenmary.org](mailto:jgrosek@glenmary.org) or shown to the Mountain Managers and then carried by the designated adult.

**Minor Info**

Gender: Female \_\_\_\_\_ Male \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

**Medical Info**

Insurance Company: \_\_\_\_\_

Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Health Info**

Known Allergies: \_\_\_\_\_ Medical Allergies: \_\_\_\_\_

Conditions youth is currently receiving treatment: \_\_\_\_\_

Any other significant medical information: \_\_\_\_\_

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

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for \_\_\_\_\_ (hereafter "Designated 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 Designated Adult to summon any and all professional emergency personnel to attend, transport and treat the minor 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. I agree to assume financial responsibility for all expenses of such care.

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 Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: \_\_\_\_\_. Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Parent/Legal Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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