AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR FORM

PART I. Identification

I/We, (Parents) _____ of (address)_____
are the (Parents /Guardians) _____ of (Pathfinder) _____ .

PART II. Authorization

We authorize_____ to consent to x-ray, examination, anesthetic, hospital care, medical or surgical diagnosis or treatment to be rendered to _____ when the need for such care is immediate and when efforts to contact us are unsuccessful.
(Pathfinder's name)

PART III. Duration

We understand this authorization is valid from Sept 2015 – May 2016 (or for other dates as entered below and initialed by the parents). The purpose of this authorization is our unavailability due to a Pathfinder club activity such as a campout or field trip.

Other authorized dates: _____, Initials _____
_____, Initials _____
_____, Initials _____
_____, Initials _____
_____, Initials _____

Part IV. Information

Pathfinder's birth date: ___/___/____

Physician _____(___) _____
Insurance – Medical _____(___) _____

Dentist _____(___) _____
Orthodontist _____(___) _____
Insurance – _____(___) _____

Last Tetanus Shot _____ Allergies _____ Medicines _____
Existing Medical Conditions _____

Home phone # ___-___-____ Father's work # ___-___-____

Pagers _____

Father's signature – _____ Date _____ and/or

Mother's signature – _____ Date _____

Other information (timing of medicines, special instructions,…) _____
_____
_____

_____