Emergency Medical Treatment Authorization Form

Youth Programs

Participant Information

Full Name

Date of Birth

Home Address

Phone Number

Program Name

Parent/Guardian Information

Parent/Guardian Name

Relationship

Phone Number

Alternate Emergency Contact Name

Alternate Contact Phone

Medical Information

Physician Name

Physician Phone

Health Insurance Provider

Policy Number

List any allergies

List any medications currently taking

Medical conditions/special instructions

Authorization and Consent

I hereby authorize the above-named program and its staff to secure any and all necessary emergency medical treatment for my child/ward named above, in the event I cannot be reached or am not available. I understand that I am responsible for all costs incurred for such treatment.

Parent/Guardian Signature

Date