YEOT Medical Treatment Authorization Form

Child

Last Name: ______________ First Name: ______________ Middle Initial: ____

Date of Birth: ______________ Gender: ______ ______________

Treatment that the child is currently receiving:

____ __________

Allergies: __________

____ __________

____

____

Doctor's Information

Doctor's Name: ____

Clinic Address: ____

Office Phone Number: ______________ Emergency Phone Number: ______________

Medical Insurer/Health Plan: ______________ Policy #: ______________

Parent(s)/Legal Guardian(s):

Parent #1:

Last Name: ______________ First Name: ______________ Middle Initial: ____

Address: ____

Home Phone Number: ______________ Work Phone: ______________

Cell Phone: ______________ Pager: ______________

Email: ______________

Additional Contact Information: ______________________________

Parent #2:

Last Name: ______________ First Name: ______________ Middle Initial: ____

Address: ____

Home Phone Number: ______________ Work Phone: ______________

Cell Phone: ______________ Pager: ______________

Email: ______________

Additional Contact Information: ______________________________

____

Emergency Contact:

Name: ____

Address: ____

Home Phone Number: ______________ Work Phone: ______________

Cell Phone: ______________ Pager: ______________

Email: ____

Additional Contact Information: ______________________________

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

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

I grant my authorization and consent for Young Engineers Of Today ________ to:
Supervising Adult

☐ Administer general first aid, including approved medication, CPR and Epi-Pen.

☐ Seek medical attention for the child, including contacting medical personnel and transporting child to the necessary clinic or hospital.

☐ Issue consent for any medical procedure, transfusion, medication, treatment or care diagnosed and administered by any licensed physician, surgeon, dentist, or medical personnel.

This authorization is given, prior to any immediate or pressing medical need, in order to provide the power of decision and the authority to act on the prudence and judgment of the Supervising Adult, with the provided input of authorized medical personnel.

This medical consent is authorized to begin on the ______ day of ________________ 20 _____
and will cease to be in effect on the ______ day of ________________ 20 ________

Signed this ___________ day of _________________ 20 ________

____
Parent #1's Signature

____
Parent #2's Signature