EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating in Youth Court when parents or guardians cannot be reached.

NAME OF
CHILD_____
(Print)

Consent: The Youth Court Hearing Captain and/or Coordinating Volunteer:
____Has _____Does Not Have My Permission
if he/she considers it necessary to call a physician or emergency care assistance for my son/daughter in case of sickness or accident. I understand that in the event of a serious emergency, I will be notified immediately for further instructions. I also understand that I am responsible for any medical expenses related to my child's care.

In the event reasonable attempts to contact me at the numbers given on this form have been unsuccessful, I hereby give my consent for:

(a) The administration of any treatment deemed necessary by our family practitioners:
Dr. _____(preferred physician) at _____(phone)

Dr. _____(preferred dentist) at _____(phone)
OR

(b) in the event the designated practitioners are not available, by another licensed physician or dentist.

I also grant permission to transfer the child to the nearest medical facility.
Hospital of choice _____ (Hospital name)
This authorization does not cover major surgery unless medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

_____
Emergency Contact (PRINT) and Phone Number

_____
Alternate Emergency Contact (PRINT) and Phone Number

Information concerning the child's medical history including medical allergies, medication, or impairments to which a physician should be alerted.

_____

_____

_____ _____ _____
Parent/Guardian Name (PRINT) Signature of Parent/Guardian Date