CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

NAME OF EVENT(S): ______________________ **DATE(S) OF EVENT:** ______________

CHILD'S FULL NAME: ______________________ Birth Date: __________ Age: ________

PARENT/GUARDIAN #1: Name: ______________________ Address: ______________________

Phone: Home ________________ Cell ________________ Work ________________

PARENT/GUARDIAN #2: Name: ______________________ Address: ______________________

Phone: Home ________________ Cell ________________ Work ________________

ALTERNATE CONTACT in the event Parents/Legal Guardians cannot be reached:

Name: ______________________ Address: ______________________

Phone: Home ________________ Cell ________________ Work ________________

Additional Contact Information ____

MEDICAL INFORMATION:

Allergies to medications: ____

Allergies (other, including food); please specify: ____

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If applicable, please note the conditions for which the child is currently receiving treatment or medication: ________________

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If your child is required to take medication prescribed by a physician during the course of this event, and you wish MCFTA personnel to assist your child in taking this medication, please indicate by signing below. In addition, please state the type of medication and provide a statement from the child's physician detailing the method, amount and time schedules by which such medication is to be taken.

Medication: ____

Physician Statement attached: YES NO

In the case that I desire my child to apply sunscreen or insect repellant, I agree to supply said materials to MCFTA labeled with my child's name and application instructions. MCFTA camp personnel cannot apply these materials, but will supervise the application by the child.
By signing or typing my name in the space below, I represent that I have legal custody of the above mentioned child.
Name (s) Parent/Guardian: ____

NOTE ANY OTHER SPECIAL CONSIDERATIONS REGARDING YOUR CHILD: ______________________

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AUTHORIZATION AND CONSENT OF PARENT(S)/LEGAL GUARDIAN(S): I grant authorization and consent for MCFTA to administer general first aid treatment for any minor injuries or illnesses experienced by the minor.

In case of serious accident or serious illness, I request the MCFTA to contact me prior to rendering treatment to the patient. If the MCFTA is unable to reach me, I hereby authorize the MCFTA to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any 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. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care but is given to provide authority and power to render care which medical or emergency personnel may deem advisable.

I agree to be financially responsible for any costs or expenses which are incurred in the above. I agree that any disclosure or use of any protected health information for my child pursuant to statements made or actions taken in accordance with this form shall not be violations of the federally protected rights under the HIPAA Privacy Rule, and I knowingly waive such privacy for these purposes.

By signing or typing my name in the space below, I represent that I have legal custody of the above mentioned child.

Name(s) of Parent or Guardian: ______________________ Date: ________________

In advance of your event or program start date, please fill out this form completely, save and email to your program contact OR return two (2) signed, printed copies to the MCFTA Administrative Offices.

Revised August 2014