**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

In my absence, I authorize

_____

(adult into whose care minor(s) is entrusted)

to act in my place to consent to medical treatment or hospital care as deemed advisable by any licensed physician/surgeon.

I assume financial responsibility for the delivery of such care.

Medical insurance company _____

Policy No. _____

Doctor's Name _____ Phone _____

| Youth's Name(s) | Birth Date……. | Blood Type | Weight | Allergies……. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Address _____ Phone _____

I can be reached at _____ Phone _____

Another person to notify in an emergency _____

Relationship _____ Phone _____

Signed _____
(mother/father/legal guardian)

Date _____

Event _____