

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD

We _____ and _____ do hereby state that we are the natural parents and/or have legal custody of _____ age _____. We authorize Tim Croy and/or any agents or representatives of the Berea Diving Club to consent to any examination, anesthetic, X-ray, medical or surgical diagnosis or treatment and/or hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice when efforts to contact us are unsuccessful. This consent is granted for the duration of membership in the Berea Diving Club.

(parent or guardian signature) (date)

EMERGENCY INFORMATION

I, _____ request that the following information be considered when medical treatment is rendered to _____.

Known allergies _____.

Medication child is taking _____.

Medical History _____.

Choice of Hospital or Facility _____.

Choice of Physicians(s) _____.

Child's Home Address _____ Phone _____

Parent's or Guardian's Home Address _____ Phone _____

Possible location of parent(s) or guardian(s)
LOCATION

Home _____ Phone _____ Work _____ Phone _____

Other _____ Phone _____ Other _____ Phone _____

(parent or guardian signature) (date)