



Medical Treatment Authorization Form

(Youth's Name) (Date of Birth)

(Address, street and city) (Date)

I hereby request and permit any medical personnel, hospital and the physician(s) and hospital personnel it may wish to designate to render the above-named minor any medical and/or surgical treatment he/she may require while on an authorized outing with the White Pines United Methodist Youth Group from January 1, 2005 to December 31, 2005.

(Signature of parent or legal guardian) (Phone Number)

(Regular Physician's name) (Phone Number)

(Your Insurance Company) (Policy Number)

Is Youth currently on any medication? No Yes

If yes, please list the name of the medication and the dosage instructions:

(Medication) (Dosage)

(Medication) (Dosage)

(Medication) (Dosage)

Please describe any known allergies or other pertinent medical information:

(Allergies) (Other medical information)

Please list a second contact person in the event you cannot be reached:

(Name) (Relationship) (Phone Number)