MEDICAL TREATMENT PERMISSION FORM

Participants Name _____ Date of Birth_____

I, _____, hereby give my permission, consent and authorization for any medical treatment deemed necessary by a hospital or physician. I appoint the event coordinator and/or director my lawful agent with power to authorize and consent to the administration of medical treatment during the aforementioned event.

Home Phone (_____)_____ Alternate Phone (_____)_____

Health Carrier: Policy No.: _____

Other Emergency Contacts: _____

Please list all allergies, restrictions or health exceptions: _____

_____

This form should be properly signed and turned in at the time of registration. In case of such accident or illness, I give permission for medical treatment to be given to me as deemed appropriate. I will assume responsibility for any medical treatment as deemed appropriate. I will assume responsibility for any medical bills incurred on my behalf.

_____

Participant Signature

_____

Parent (if Participant is under 18 years of age OR a dependent on parent's insurance and taxes for the period of the event)