

Discover Life After School Program

MEDICAL AUTHORIZATION FORM

Consent for Emergency & Routine Medical Treatment of a Minor Child • Confidential

THIS FORM IS PROVIDED TO / FOR (e.g. School, Daycare, Camp, Church, Sports Team, Babysitter, Travel Group):

Child's Full Legal Name (First Middle Last)

CHILD'S INFORMATION

Date of Birth (MM/DD/YYYY) Age Gender (M / F / Other)

Home Address (Street, Apt/Unit)

City, State, ZIP Code Home / Primary Phone

PARENT / GUARDIAN INFORMATION (at least one required)

Guardian 1 (Primary Contact)

Full Name Relationship (Mother / Father / Guardian / Other)

Cell / Primary Phone Work / Alt Phone Email Address

Guardian 2 (Optional)

Full Name Relationship

Cell / Primary Phone Work / Alt Phone Email Address

EMERGENCY CONTACTS (other than parents/guardians above — at least two recommended)

Emergency Contact 1

Full Name Relationship Primary Phone (Cell)

Emergency Contact 2

Full Name Relationship Primary Phone (Cell)

CHILD'S HEALTH INFORMATION • ALLERGIES & MEDICAL ALERTS (CRITICAL — COMPLETE FULLY)

ALLERGIES / SENSITIVITIES (check if none, or list all known — include medications, foods, insects, latex, environmental, etc.)

If any allergies, list details here (type, reaction severity, EpiPen required?):

No known allergies

Primary Physician / Pediatrician Name Phone Number

Health Insurance Company Policy / Member ID # Group #

Significant Medical Conditions, Chronic Illnesses, Disabilities, or Special Needs (asthma, diabetes, seizures, ADHD, autism, etc.)

Current Medications (name, dosage, frequency, reason) or write 'None'

AUTHORIZATION, CONSENT & RELEASE (Read carefully before signing)

I, the undersigned parent or legal guardian of the minor child named above, hereby authorize any licensed physician, dentist, nurse practitioner, hospital, clinic, or other qualified medical provider to provide any necessary medical, dental, surgical, diagnostic, or emergency treatment for my child. This includes (but is not limited to) physical exams, lab tests, x-rays, CT/MRI, anesthesia, medications, immunizations, blood transfusions, minor/major surgery, and hospitalization when deemed medically necessary. This authorization applies while my child is participating in or under the care/supervision of the program or organization named on this form (school, daycare, camp, sports, church, travel, or other activities). I understand reasonable efforts will be made to contact me or the emergency contacts listed before non-emergency treatment, but I grant permission for immediate treatment if delay would harm my child. I authorize release of my child's protected health information to treating providers and to the program/organization as needed for care coordination, consistent with HIPAA and state privacy laws. I agree to be financially responsible for all medical costs incurred. This form is valid from the date signed until revoked in writing or until the end date noted below. A copy of this signed form has the same legal effect as the original. I certify that all information I have provided is accurate and complete. I understand that incomplete or inaccurate information could place my child at risk.

This authorization is valid from: to: (or until written revocation is provided)

PARENT / GUARDIAN SIGNATURE & ACKNOWLEDGMENT

Signature (sign here or type full legal name if submitting digitally):

Date Signed:

Relationship:

Printed Full Legal Name of Signer:

Phone (day of):