AUTHORIZATION FOR MEDICAL TREATMENT

Full Legal Name: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Emergency Contact: _____

Phone:

Home: Work: Cell:

Doctor's Information:

Doctor's Name: _____

Doctor's Address: _____

Doctor's Office Phone: _____

Primary Health Plan Information:

Medical Insurer/Health Plan: _____

Policy ID# _____ Group # _____

Insured's Name _____

Full Legal Name (First Name, Middle Initial, Last Name)

Insured's Birth Date: _____

Insured's Address: _____

Insured's Employer Name: _____

Secondary Health Plan Information:

Medical Insurer/Health Plan: _____

Policy ID# _____ Group # _____

Insured's Name _____

Full Legal Name (First Name, Middle Initial, Last Name)

Insured's Birth Date: _____

Insured's Address: _____

Insured's Employer Name: _____

Allergies to Medications: _____

Other Allergies _____

If applicable please note the conditions for which you are currently receiving treatment:

_____

_____

Note any other significant medical information: _____

_____

Names of Medications, doses and amount taken: _____

_____

Dentist's Information:

Dentist's Name: _____

Address: _____

Office Phone: _____

Dental Insurance Plan

Insurer/Health Plan: _____

Policy ID# _____ Group # _____

Insured's Name _____

Full Legal Name (First Name, Middle Initial, Last Name)

Authorization and Consent for Treatment

I grant my authorization and consent for **Helping Hands Mission Camp** (hereafter Supervising Adult) to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If

It is understood that this authorization is given in advance of any such medical treatment, but is given

_____ Date: _____

Legal Guardian's Signature