

CONSENT FOR TREATMENT

HARMONY EXPLOSION CAMP 2010

PARENT/GUARDIAN *APPROVAL* FOR TREATMENT

Please send to chapter with Student Registration

I hereby authorize medical personnel to administer treatment or procedures that in their judgment may be necessary for:

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent, Guardian, or Next of Kin

ADDRESS \_\_\_\_\_

Street

city

State, Zip Code

Telephone numbers (Home/Work) including area code

MAY WE PUBLISH PICTURES OF YOUR SON??? YES \_\_\_\_\_ NO \_\_\_\_\_

You will be notified should it become necessary to refer the above named to a medical facility.

FAMILY PHYSICIAN:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

HEALTH INSURANCE COMPANY THAT INSURES FAMILY AND PATIENT:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

**SEND WITH REGISTRATION to Sponsoring chapter**

**Chapter Send in WITH REGISTRATION**