CONSENT TO TREAT FORM

I, the undersigned parent or legal guardian of the participant named below, do hereby authorize treatment of said participant by licensed medical physician in case of any accident or illness that may arise, or any hospitalization necessary.

Participant Name: ____________________________________

Birth date: ____________________________________

Does the participant have any medical conditions?

Asthma__ Diabetes__ Allergies__ Insect bite reactions__ Hay Fever__ Other__

If yes, any additional information of which we should be aware?

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Medications being taken and frequency:

Medication	Frequency

Emergency Contact Name: _______________________

Phone Number: _________________________

Family Physician: _______________________ Phone Number: ________________

We have a first aid kit and some medical supplies such as Tylenol and Advil.
May we use our discretion in providing these as needed? **YES ____ NO ____**

Is there any medication that **should NOT** be given? ______________________________

Date Signed: _______________________

__________________________	__________________________
Participant (print)	Parent or Legal Guardian (print)
__________________________	__________________________
Participant (Signature)	Parent or Legal Guardian (Signature)