Emergency Medical Authorization for Participants Under 18 Years of Age

CHILD'S NAME: _____ PHONE: _____

ADDRESS: _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under 4-H Camping, 4-H Club Activities, and or sponsoring agency authority, when parents or guardians cannot be reached.

Part I or II Must be Completed

PART I (To Grant Consent)

In the event reasonable attempts to contact me at _____(phone#) or _____ (other parent/guardian) at _____(phone#) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (Preferred physician) at _____ (phone#) or Dr. _____ (Preferred dentist) at _____ (phone#) or in the event the designated practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

_____

_____

Signature Date

Address: _____

Part II (Do not complete Part II if you completed Part I)

I **do not** give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish 4-H Camp Ohio and the sponsoring agency authorities to take no action or to

_____

_____

_____

Signature Date

Address: _____