

CONSENT FOR TREATMENT

HARMONY EXPLOSION CAMP 2008

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