Envision the Future

A STEM Program for Girls Ages 11 - 13

A Southeastern Massachusetts STEM Network Initiative in Collaboration with CONNECT

AUTHORIZATION FOR MEDICAL & EMERGENCY TREATMENT

Student's Name (Please Print): _____

As the Parent or Legal Guardian of the above named child, I hereby authorize the Envision the Future Program to render (or acquire) competent medical treatment when, deemed necessary.

<u>To assist in the care of my child, the following information is provided</u>:

Known Allergies: _____

Medical History (i.e. Diabetes, Asthma, Seizures, etc.): _____

_____

List any Medications your child is currently taking: _____

Time(s) of Day Administered: _____

Child's Primary Doctor: _____Phone Number: _____

Dietary Restrictions: ___None ___No red meat ___ No poultry ___ No dairy

___ No seafood ___ No pork ___No eggs ___ No Nuts ___ Gluten Free

Describe any restrictions to activity:

_____

PARENT (Legal Guardian) INFORMATION & AUTHORIZATION

Name (Please Print): _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____

Please Provide Insurance Information on the Back of this Form

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INSURANCE INFORMATION

Company: _____ Subscriber's Name _____

Policy #:_____ Group #: _____

I authorize medical release to transport. I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

_____ _____

Parent/Guardian Signature Date