

2016-2017

**AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT
OF A MINOR CHILD**

We _____

and _____

do hereby state that we are the natural parents and/or have
legal custody of _____

age _____, We authorize Lubbock Dive Club
to consent to any examination, anesthetic, X-ray, medical or
surgical diagnosis or treatment and/or hospital care to be
rendered to the minor under the general or special supervision
and on the advice of any physician or surgeon licensed to
practice when efforts to contact parents or guardian are
unsuccessful.

Birthdate of Diver: _____

This consent is granted for a period of one year.

_____/_____/_____
Signature **Date**

Contact Information

We want to get information to you as quick as possible.
Therefore your e-mail address and cell numbers are very
important. If practice has to be cancelled unexpectedly
or if we are at a meet and we need to reach you, it will
make it easier to do so.

E-mail address: _____

Cell Phone numbers:

Mother: _____

Father: _____

Diver: _____

EMERGENCY INFORMATION

I, _____
request that the following information be considered
when medical treatment is rendered.

Known allergies: _____

Medication child is taking: _____

Medical History: _____

Choice of Hospital or Facility: _____

Choice of Physician(s): include Specialists

Parents or Guardians Home Address:

City **State** **Zip**

Possible location of parent(s) or guardian(s)

Location	Phone
<u>Home</u> _____	() _____
<u>Work (Mother)</u> _____	() _____
<u>Work (Father)</u> _____	() _____

Other Relative's Name	Relation	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signed: _____ **Date:** _____