MEDICAL INFORMATION AND RELEASE FORM – MINOR (DOMESTIC CAMP)

Minor's Name
Address:
City: State: Zip:
Telephone Number: Birthdate:
Gender:

Parent or Guardian Name:
Address:
City: State: Zip:
Telephone Number email:

Emergency Contact Name (other than parent or guardian):
Address:
City, State Zip:
Telephone Number: email:

Physician Name: Dentist Name:
Telephone Number: Telephone Number:

Allergies: Blood Type:
Current Medications and dosage: Date of Last Tetanus/Diphtheria Vaccinations:
Special Health Needs or Concerns:

Health Insurance Carrier Name: Phone Number
Policy Holder Name: Policy Holder Date of Birth
Policy Number: ID Number:

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of do hereby authorize emergency medical or surgical treatment and hospitalization if necessary for the above named minor. I understand that an attempt will be made to contact me, or the named emergency contact, before taking this action. If I or the emergency contact, cannot be reached, the Championship Mock Trial Academy and its designated representatives may consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered to upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization. The effective dates for this authorization are **July 14, 2024** through **July 21, 2024**.

By signing this authorization, I represent to the Championship Mock Trial Academy that I have legal authority to provide consent for this minor child.

Signature of Parent or Guardian Date