

Emergency Medical Treatment Consent and Authorization Form

Please note: Medical treatment cannot be provided to an unaccompanied competitor without a copy of this parental/guardian consent per Article 39 of the Two Rivers Féile syllabus.

I, _____, (Parent/Guardian) of

_____, (Daughter/Son)

Born on _____, do hereby give my formal consent to said care provider,

_____ to secure and authorize any such form of emergency treatment and/or medical treatment, for the above named minor, in the event that she/he would require medical care while under the supervision of said care provider. Any/all treatment deemed as necessary will be determined at the sole discretion of above stated care provider.

As parent/guardian of _____, (daughter/son) I, _____ (Parent/Guardian) also agree to pay all the costs and fees contingent on emergency medical care and/or medical treatment for the above stated minor person as secured and/or authorized under this consent.

PLEASE NOTE: Every effort will be made to notify the parents/guardian in case of an emergency.

In the even of an emergency, the following information will be utilized:

Physicians Name: _____

Telephone Number: _____

Preferred Hospital: _____

Address: _____

Telephone: _____

Please Note: A Des Moines, Iowa hospital will be utilized and selected by medical personnel if no specific Des Moines, Iowa hospital is designated on this form. In the event of a life threatening event, any/all medical and hospital decisions will be at the sole discretion of medical personnel and/or emergency medical response unit.

Alternative relative or person(s) to contact in the event of an emergency:

Name: _____

Address: _____

Telephone (home or mobile): _____

Relationship to minor: _____

Signature of parents/guardian: _____ Date: _____

Signature of Daughter/Son: _____ Date: _____

Care Provider Signature: _____ Date: _____