

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

This form is mandatory if minor is being accompanied by an adult other than a parent or guardian. No such minor will be allowed to enter and compete without this completed form.

NAME of competitor: _____

NAME of parent/guardian: _____

ADDRESS: _____

CITY: _____ ST: _____

ZIP: _____ Telephone number: _____

This authorization applies to my child, named above, who is under 18 years of age. I have authority to consent to medical treatment to my child. In my absence, and in the event I cannot be contacted after a reasonable effort has been made, I hereby give authority to:
to consent to medical treatment to my child named above. I agree to be financially responsible for medical expenses incurred by reason of such treatment.

Signature-Parent/Guardian: _____ Date: _____

MEDICAL INFORMATION

Allergies:

Medications:

Last Tetanus Booster:

Other:

Pediatrician OR Family Doctor:

MD Address:

MD Phone:

Hospital:

Medical Insurance Company:

Policy Holder:

Policy Number:

Certificate #: