Authorization for Medical Treatment

PLEASE PRINT (*Update for each event requiring medication*)

Last Name ___________________ **First Name** _________________ **Middle Initial** ______

Age ______ Date of Birth ___/____/____ Social Security Number _________________

Home Street Address ____

City _______________ State___ Zip Code ______

Parent/Guardian Name ________________________________

Relationship _______________

Home Street Address ____

City _______________ State___ Zip Code ______

Home Number (____)_____________ Work Number (____)_____________

Mobile Number (____)____________ Pager Number (____)_____________

Other Number (_____)____________

PART I: Medical Consent (*Parent or Legal Guardian is required to complete*)

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize that my child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary.

Parent or Legal Guardian _____________________________ Date ____________

PART II: Permission to Use Over-the-Counter Medication (*If not completed, Young Marines will not receive medication*)

My child, ___________________________, has my permission to take any over-the-counter medications in accordance with label instructions as needed with the exception of:

____ while attending Young Marine Activities.

Parent or Legal Guardian ______________________________ Date ___________