

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I am the parent/guardian of _____

Subject to the conditions set forth below, I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by the Girl Scouts of the United States of America, the Girl Scout Council of the Nation's Capital, or individual units.

Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers listed below. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to:

- (i) the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Girl Scout adult leader; and
- (ii) the immediate administration of life-sustaining measures deemed necessary under the circumstances.

Health Information

The following information may be needed by a medical doctor and/or medical facility not having access to your child's medical history:

Allergies: _____
 Medicine being taken: _____
 Date of last tetanus shot: _____
 Physical impairments: _____
 Other pertinent facts to which a medical doctor should be alerted: _____

Insurance Information

Company: _____ Policy Number: _____
 Policyholder's Name: _____

Father's/Guardian's Name:

Mother's/Guardian's Name:

Address _____

 Daytime Phone _____
 Evening Phone _____

Address _____

 Daytime Phone _____
 Evening Phone _____

If I cannot be reached in the event of an emergency, the following person is authorized to act on my behalf (designated alternate): _____

Daytime Phone: _____ Evening Phone: _____ Relationship: _____
 Preferred Medical Doctor/Medical Facility: _____
 Daytime Phone: _____ Evening Phone: _____

Signature of Parent or Guardian

Date