Medical Authorization Form

In case of an emergency, _____ has my
(Facility Name Where Child Will Be)
consent to authorize medical care for my child(ren) listed below:

_____ _____

_____ _____

_____ _____

Our family physician is: _____

His/her address: _____

His/her telephone # is: _____

Our hospital preference is: _____

Allergies/Medical Conditions: _____

_____

Contact me immediately at: _____

If unable to contact me, please call:

_____ @ _____

Name Telephone

_____ @ _____

Name Telephone

Insurance Company Covering Child: _____

Policy Number: _____ Group Number: _____

Signed By

_____ _____

Printed Name Signature

Address: _____

Telephone: _____ Date: _____

BOOST Gymnastics