

**PARENT PERMISSION AND MEDICAL CONSENT FORM**

Child Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Social Security # \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Parental Consent:

(I) (We), the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby consent to said Minor participating in "**Boot Camp with a Judge**" (explain activity) conducted by **Dee Ann Allen**.

**Authorization of Consent to Treatment of Minor:**

Child Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Social Security # \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

(I) (We), the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby consent to said Minor participating in "**Boot Camp with a Judge**" (explain activity) conducted by **Dee Ann Allen**.

**Authorization of Consent to Treatment of Minor:**

(I) (We), the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby authorize **Dee Ann Allen**, hereinafter "Agent", for and on behalf of the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital, during all times that the Minor is in the presence of said Agent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable, and release Agent from all damages of same.

This authorization shall remain effective through the **1<sup>st</sup> day of June, 2010**, unless sooner terminated in writing.

Parent \_\_\_\_\_

Date: \_\_\_\_\_

Parent \_\_\_\_\_

Date: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Other phone number: (\_\_\_\_\_) \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ If None Please Check: \_\_\_\_\_

Insurance Policy Name and #: \_\_\_\_\_

Known Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications? \_\_\_\_\_

Allergies? \_\_\_\_\_

Last Tetanus Immunization? \_\_\_\_\_

Will You Allow Blood Transfusions? (check your response) Yes \_\_\_ No \_\_\_

Other Comments: