MEDICAL TREATMENT AUTHORIZATION
Eastfork Farm, Augusta, MI 49012

Please compete this form to give an appropriate medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury of illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay**.

Participant's name_____ Birthdate_____

Address_____ Phone_____

_____

Name of primary care physician_____

Address of physician_____

Phone number of physician_____

INFORMATION NEEDED ABOUT PARTICIPANT

Please check yes or no. If yes, explain below or on another sheet if you need more room.

YES NO

___ ___ Does the participant have any chronic problem or illness?
___ ___ Does he or she have any acute illness now?
___ ___ Has the person been treated recently for some medical problem?
List any medications he or she is now taking for treatment of any medical problem?
___ ___ Does the participant have any allergies to medication or local anesthetics?
___ ___ Does he or she have any allergies?
Date of his or her last tetanus shot_____

HEALTH INSURANCE INFORMATION

Policy holder's name and relationship to participant_____

Policy holder's address_____

Name and address of insurance company_____

If you have HMO or PHP insurance company please list emergency phone number for treatment authorization purposes_____

Name and address of employer_____

Business phone_____ Subscriber's social security number_____

All policy numbers (please identify)_____

OFFICIAL AUTHORIZATION FOLLOWS:

I, _____, parent or legal guardian residing at

_____

(street number) (street) (city) (state) (phone)

do hereby authorize **Eastfork Farm** to seek any medical or surgical treatment necessary for the care of my child.

The above-designated organization is hereby authorized to incur medical costs necessary to provide medical treatment for the said child for which I shall be fully responsible. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Parent's/Guardian's Signature_____

Date_____