Medical Treatment Authorization Form for a Minor

This form grants temporary authority to International Sports Federation (hereafter "ISF") employees, representatives or agents to arrange medical care for a minor (under 18 years old) in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form will be given to and carried by the designated ISF personnel.

Minor

Full Legal Name: _____

Home Address:_____City_____State_____Zip_____

Date of Birth:_____/_____/_____ Gender: Female_____Male_____

Information for Medical Treatment

Physician's Name and Location of Practice:

Name:_____

City_____State_____

Physician's Phone # (if known): (____)_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment:

_____

Note any other significant medical information (attach additional paperwork if needed):

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for ISF employees, representatives or agents to have general first aid treatment administered for any minor injuries or illnesses experienced by the Minor and to make appropriate decisions regarding clothing, bodily nourishment and shelter. If the injury or illness is life threatening or in need of emergency treatment, I authorize the designated ISF employees, representatives or agents to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state or country in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the designated ISF employees, representatives or agents in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective: Date:_____/_____/_____ to Date____/____/_____.

Signed this _____day of_____, 20___.

Parent/Legal Guardian Signature: _____Printed Name:_____

Witness Signature: _____Printed Name:_____