Authorization for Medical Care of a Minor

I/We, the undersigned parent(s) or legal guardian of the minor listed below:

_____

(Minor's Name) ***Please Print***

_____

(Minor's Birthdate)

do hereby authorize AFR Cooperative to consent to any X-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by/from the nearest licensed medical facility that may be rendered to said minor under the general, specific, or special consent of the AFR Leadership Summit staff, the temporary custodian of the minor, whether such diagnosis or treatment is rendered at the office of a licensed physician or dentist, or at another licensed medical facility. I/We, authorize the physician or dentist to call in any necessary consultants, at his/their discretion. I also authorize officials to secure the use of an ambulance, if necessary, for transporting my child to the hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical, dental, or surgical treatment.

The above named child is currently covered by the following medical/hospitalization plan: _____

_____ Group/Policy Number _____.

The undersigned agree to cooperate with AFR Cooperative in the preparation, execution and processing of any and all paper work necessary to submit claims for any medical care, surgical care and prescriptions provided to the child under this authorization. As the parent or guardian of the child, the undersigned agrees to be responsible for all costs incurred for medical care provided to the child not covered by insurance and agrees to indemnify and hold AFR Cooperative harmless for any and all costs incurred in securing medical care and treatment for the child as defined above.

This consent shall become effective on the first day of the AFR Leadership Summit my child is attending and shall terminate upon return of the minor child to my custody, unless sooner revoked in writing, delivered to said physician or dentist or to said persons entrusted with the custody, care, and control of said minor child.

X _____ Date_____

Signature of Parent or Legal Guardian

Are you currently taking any prescribed medication? _____

_____

Allergies _____

Allergic reactions to certain drugs or foods_____

Date of Last Tetanus Shot _____

Any medical conditions we should know in case of a medical emergency? Please explain:

_____

_____

PLEASE ATTACH A PHOTO COPY OF INSURANCE CARD

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_____ Father's Signature	_____ Mother's Signature
_____ Father's Home Address	_____ Mother's Home Address
_____ Father's Home Phone Number	_____ Mother's Home Phone Number
_____ Father's Work Phone Number	_____ Mother's Work Phone Number
_____ Father's Cell Phone Number	_____ Mother's Cell Phone Number
_____ Legal Guardian's Signature (If different than Mother and Father)	_____ Family Doctor
_____ Legal Guardian's Home Phone Number	_____ Family Doctor's Office Number:
_____ Legal Guardian's Work Phone Number	_____ Legal Guardian's Cell Phone Number

In addition to parents and/or legal guardians, please list any other person(s) to contact in case of emergency:

_____ Name	_____ Day Phone Number
_____ Relationship	_____ Evening Phone Number
_____ Name	_____ Day Phone Number
_____ Relationship	_____ Evening Phone Number

THIS FORM MUST BE COMPLETED AND RETURNED TO CARA COMSTOCK ON THE OPENING DAY OF LEADERSHIP SUMMIT IN ORDER FOR THE STUDENT TO PARTICIPATE.