



Authorization Form For Emergency Medical Treatment of Minors

Name of Minor: _____

Birthdate: ___/___/___ Phone # to contact in case of Emergency:(____) _____

Identify Allergies: _____

Medication Needs: _____

Special Conditions: _____

I/we being the parents(s) or legal guardian(s) of the above named minor, do hereby appoint Chrysalis Team Officials to act in my/our behalf in authorizing necessary medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence from:

++++
This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.
++++

Parent/Guardian (signature) _____

Address _____ Date: _____

Witness
(signature) _____ Address _____

_____ Date: _____

Parent/Guardian (signature) _____

Address _____ Date: _____ **Witness**

(signature) _____ Address _____
_____ Date: _____

Hospitalization coverage for above named minor:

Insurance Company Name: _____

Policy I.D./Contract/Number: _____

Family Physician:

Name and Phone Number: _____

This document must accompany any minor (under 18 years of age) staying overnight for a Chrysalis event. No document-No stay!