



BELIZE MISSION AND RETREAT

Attn: Rae Reed
23950 S. Chrisman Rd.
Tracy CA 95304
877-721-6222

e-mail: turtleshores@belizemission.org
website: www.belizemission.org

Authorization for Emergency Medical Care to Minor

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

Minor's Name _____

Birth Date _____

Do hereby authorize any necessary examination, anesthetic, dental, medical or surgical diagnosis or treatment by a duly licensed physician or dentist and hospital service that may be rendered to said minor under the guardian, specific, or special consent of:

_____ (Team Leader Who Is Temporary Custodian)

The temporary custodian of the minor, whether such diagnosis or treatment is rendered at the office of the physician or dentist, to call in any necessary consultants at his/their best judgment as to the requirements of such diagnosis or medical, dental, or surgical treatment. It is further understood that those persons who have temporary custody of said minor will attempt to talk with the parent(s)/legal guardian(s) via the telephone numbers listed below before treatment is rendered.

Consent for Dates: _____ through _____

One parental signature is required:

Father: _____

Mother: _____

Legal Guardian: _____

Address: _____

Daytime Telephone: _____

Evening Telephone: _____

Person(s) to be reached if parent/guardian cannot be reached"

Name Phone

Name Phone

To your knowledge, is your child allergic to any medication? Yes No

If yes, what medication? _____

Will your child be taking any medication while in the care of the above temporary custodian? Yes No

If yes, what medications? _____

Does your child have diabetes, hypoglycemia, or other medical disorder which the adult leader should be aware? Yes No

Please Staple Photocopy(front and back) of Medical Insurance Cards to This Form

Notarization Stamp here: