Massachusetts law requires that consent be obtained from a Parent or Legal Guardian of a Child under 18 years of age before medical care can be administered. Such authorization may be delegated to another person over the age of 18.

AUTHORIZATION FOR CONSENT

Child: ______________________________ **Date:** ______________

Last Name *First Name* *Middle Initial* *Month* *Day* *Year*

Date of Birth: ______________ Home Phone: ______________

Month *Day* Year

Home Address: ______________________________

Street *City* *State* *Zip*

Please fill out ALL of the following information. Civil Air Patrol personnel will always attempt to contact these individuals first, should any emergency medical situation arise.

Parent/Guardian Name 1: ______________ Home Phone**:** ______________
Home address: ______________________________
Business Name: ______________ City: ______________ Work Phone: ______________

Parent/Guardian Name 2: ______________ Home Phone: ______________
Home address: ______________________________
Business Name: ______________ City: ______________ Work Phone: ______________

Doctor: ______________ **Dentist:** ______________
Address: ______________ Address: ______________
______________ ______________
Phone: ______________ Phone: ______________

Child's Allergies: ______________________________
Last Tetanus Immunization Date: __________ Chronic Illnesses: ______________
Other Medical Information: ______________________________

Medical Insurance:
Insurance Co. ______________ Policy#: ______________ Group Plan#: __________
Name of Subscriber: ______________________________

I hereby authorize personnel of the Civil Air Patrol, over the age of eighteen, to authorize necessary medical and surgical treatment, including immunization(s), for my minor child designated above to the same extent that I could have done so myself, if present. I am delegating this authority in advance of any specific injury, diagnosis, or treatment. This includes permission to have my child transferred by ambulance or emergency vehicle to a hospital.

I agree to hold harmless for failure to obtain my consent any doctor, clinic or hospital treating my child, based on this authorization. I represent that during the period of this authorization I have the proper legal custody of the child named above.

Signature: ______________________________ **Date:** ______________

Print Name: ______________________________

This authorization is good for a period of one (1) year from the date at the top of the form.