[SAMPLE]* Authorization for Medical Treatment of a Minor

I hereby authorize representatives of the program at the University of Pennsylvania to consent to emergency and urgent medical treatment for the Participant named below, including securing a medical evaluation and any treatment necessary to preserve life and bodily function unless exceptions are noted below.

This authorization shall remain in effect as long as Participant is participating in the program. Exceptions: (if none, write "none") _

Participant is allergic to the following medications: _

Other medical conditions that you wish for those providing treatment to be aware of:

* PLEASE ATTACH A COPY OF THE PARTICIPANT'S IMMUNIZATION RECORD *

Name of Participant: _

Participant's Date of Birth (MM/DD/YYYY):_

Participant's Physician name / phone number: _

Signature of Parent or Guardian: Date: _

Print Parent/Guardian Name: _

Parent/Guardian Phone:

***** ***** ***** ***** ***** ***** ***** ***** ***** ***** ***** ***** *****

Insurance Information

Is Participant covered by a health insurance plan? Yes No **

Name of Participant's health insurance company _

Policy or plan number(s)_

(*Please provide ALL numbers and/or codes to identify your plan or policy and attach a photocopy of your membership card or policy document to this form.)

Name of subscriber to policy or plan _Relationship to Participant _Name of Participant