



Youth Participant Emergency Medical Authorization Form

Please complete this form to help facilitate prompt authorization of medical treatment in the case of an emergency.

Youth Participant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Doctor: _____ Phone: _____

Residential Parent or Guardian: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Alternate Relative or Contact: _____

Relationship: _____ Phone: _____

Known allergies: _____

Last tetanus shot: _____

Additional Information/Special Instructions: _____

Attached is a copy of the participant's medical insurance card.

Parent/Guardian Signature: _____ Date: _____