APPOINTMENT OF AGENT FOR AUTHORIZATION FOR MEDICAL TREATMENT – Girl Form

The undersigned parent/legal guardian of ____ hereby appoints ______________________________________ as agent to authorize, in behalf of the undersigned, emergency medical/surgical treatment, including hospitalization, for the above named child which, in the opinion of any licensed physician, surgeon or hospital, is reasonably required or necessary for the treatment or care of said child. Any physician, surgeon or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent(s) to the same extent as if executed personally by the undersigned.

This appointment will remain valid and in full force and effect from _______________ to _______________

Our personal insurance carrier is _________________________________ Policy # _______________

The name of my daughter's physician is ____

He/She may be reached at (____) ____
(Phone) (Address)

EMERGENCY INFORMATION

_____________________________ _____________________________ _____________________
Father's Name Employer Occupation

____ (____) ______________
Mailing Address Home Telephone

____ (____) ______________
City State Zip Business Telephone

_____________________________ _____________________________ _____________________
Mother's Name Employer Occupation

____ (____) ______________
Mailing Address Home Telephone

____ (____) ______________
City State Zip Business Telephone

If parent/legal guardian cannot be reached, you should call:

Name ____ Relationship ____________

Telephone (Home) (____) ________________________ (Business) (____) _______________________

____
Signature of Parent/Legal Guardian

(Complete both pages of this form)

STATE OF ______________________________, _________________________________ COUNTY

BE IT REMEMBERED, that on this _______ day of ________________, 20____ before me, a Notary Public, in and for the County and State aforesaid, came ____, to me personally known to be the same person who executed the foregoing instrument, and duly acknowledged the execution of the same. IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal, the day and year last above written.

____
Notary Public

My appointment expires: ____________________

EMERGENCY AUTHORIZATION

I hereby give my permission to authorize emergency medical treatment in the event of injury/illness to my daughter. The health care provider is authorized to perform emergency medical services upon consent of the adult in charge from the _________________Grand Assembly, International Order of the Rainbow for Girls.

MEDICAL INFORMATION

Check all conditions which apply to your daughter. Give specific cause of allergies and any special medical information that applies.

ALLERGIES:

Drugs ____________________________________

Food ____________________________________

Hay Fever ________________________________

Insect Stings ______________________________

Poison Ivy ________________________________

DATE OF LAST:

Tetanus toxoid immunization _________________

Health Exam _______________________________

CHRONIC/RECURRING ILLNESSES:

Asthma __________________________________

Diabetes _________________________________

Ear Infections _____________________________

Epilepsy _________________________________

Heart ___________________________________

List any other current/recurring illness(es):

____

____

PHYSICAL LIMITATIONS: ____

MEDICATION AUTHORIZATION

No Rainbow Girl should keep medication in her possession. All medications must be turned in to the adults in charge.

The adults in charge have my permission to dispense:

1. My daughter's medication (circle one) Yes No
   If yes, name of medication, dosage and schedule: ________________________________
   ____

2. Non-aspirin substitute (such as Tylenol) to my daughter (circle one) Yes No
   If yes, amount: ____

* *

I certify that all of the above information is correct.

____ ___________________________

Signature of Parent/Guardian Date

(Complete both pages of this form)