PERMISSION FOR TREATMENT Faith Fest 2010

Augustana College
Sioux Falls, SD

Participant's name ________________________________ Sex ___________________

Date of birth ________________________________ Age _______________________

Allergies/dietary restrictions ____

Activity limited by physician ____

Medication child is taking __________________ Last tetanus shot ________________

Primary physician ___________________________________ Phone ______________

Medical insurance company ______________________ Policy number ____________
[Attach a copy of your insurance card, front and back.]

Should an emergency occur, Augustana College should first attempt to contact me at these phone numbers:

Daytime _______________________ Evening _______________________

Should you be unable to contact me, please notify:

Name ________________________ Relationship _________ Phone ______________

Name of church sponsoring your youth group _________________________________

In case Augustana is unsuccessful in contacting me or my alternate, I hereby authorize medical authorities to perform or arrange for whatever treatment you may consider necessary for my child.

Parent/Guardian Name (Please print) ____

Signature ____ Date ________

Address _______________________________ City/State/Zip _____________________