

# AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS

Name of Minor \_\_\_\_\_ Birthdate \_\_\_\_\_

I, Being the parent or legal guardian of the above minor do hereby appoint  
The Town of Greenfield Nordic Ski Program  
(OR) Authorized Physicians of Hospital  
to act on my behalf in authorizing emergency medical, dental, or surgical care and  
hospitalization for the above named minor during the period(s) of my absence.

This document will be presented to a physician, dentist, or appropriate hospital representative at such time  
as emergency, dental, surgical or hospitalization may be required.

## Parent/ Guardian

Name (print) \_\_\_\_\_ (Signature) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_

## HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR

Name of Insurance Company \_\_\_\_\_  
Group Number \_\_\_\_\_ Member Number \_\_\_\_\_  
Family Physician (Name) \_\_\_\_\_ Phone \_\_\_\_\_  
Known Allergies \_\_\_\_\_  
Last Tetanus Toxoid Booster \_\_\_\_\_  
Other Pertinent Medical Information (i.e. glasses, contact lenses) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_