

Authorization for Medical Treatment

PLEASE PRINT (*Update for each event requiring medication*)

Last Name _____ First Name _____ Middle Initial _____
Age _____ Date of Birth ___/___/___ Social Security Number _____
Home Street Address _____
City _____ State ___ Zip Code _____
Parent/Guardian Name _____
Relationship _____
Home Street Address _____
City _____ State ___ Zip Code _____
Home Number (____) _____ Work Number (____) _____
Mobile Number (____) _____ Pager Number (____) _____
Other Number (____) _____

PART I: Medical Consent (*Parent or Legal Guardian is required to complete*)

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize that my child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary.

Parent or Legal Guardian _____ Date _____

PART II: Permission to Use Over-the-Counter Medication (*If not completed, Young Marines will not receive medication*)

My child, _____, has my permission to take any over-the-counter medications in accordance with label instructions as needed with the exception of: _____ while attending Young Marine Activities.

Parent or Legal Guardian _____ Date _____