Episcopal Diocese of North Dakota
Medical Authorization

Event: ________________________ Dates: ________________________

Event Location: ____

Participant's Name: ____________________________ Birth Date: ____________________

Address: ____

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Guardian's Name: ________________________ Home Phone: ____________________

Cell Phone #'s (List all): ____

Alternate Contact: ____________________________ Phone #: ______________________

Medical Information:

Doctor's Name: ________________________

Allergies: ____

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Medications: ____

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Other Information: ____

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Insurance Information:

☐ I have medical insurance coverage for the above name participant.

Company: ____________________________ Policy #: _______________________

Address: ____

Policy in Name of: ____

Insurance Policy I.D.: ____

☐ I acknowledge that I do not have "medical insurance" for the above named participant and understand that we are financially responsible for all costs.

In the event of an emergency, I hereby authorize an adult leader of this activity to act as agent for me to consent to any medical, dental, or surgical treatment and care deemed necessary by a licensed medical professional. I expect to be notified as soon as possible. I acknowledge that I am financially responsible for any emergency medical or dental costs.

Guardian Name (please print): ____

Signature: ____ Date: ___________________