

*2003 Rotary International  
Western Leadership Conference  
for High School Students*

## Medical Treatment Consent Form

PLEASE TYPE OR PRINT IN INK ☞

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

PARENT'S or GUARDIAN'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ POLICY No: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY PHYSICIAN'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF LAST TETANUS IMMUNIZATION OR BOOSTER SHOT: \_\_\_\_\_

STATE MEDICAL CONDITION(S) FOR WHICH YOUR CHILD IS BEING TREATED AT THE PRESENT TIME:  
\_\_\_\_\_

LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING: \_\_\_\_\_  
\_\_\_\_\_

LIST ALL MEDICATIONS YOUR CHILD IS ALLERGIC TO: \_\_\_\_\_  
\_\_\_\_\_

LIST ANY RESTRICTIONS OF PHYSICAL ACTIVITY: \_\_\_\_\_  
\_\_\_\_\_

MEDICAL TREATMENT CONSENT AND LIABILITY RELEASE: I, THE UNDERSIGNED PARENT OR GUARDIAN, DO HEREBY GRANT PERMISSION FOR MY CHILD, TO RECEIVE NECESSARY MEDICAL TREATMENT IN THE EVENT OF AN INJURY OR ILLNESS WHILE ATTENDING THE ROTARY INTERNATIONAL LEADERSHIP CONFERENCE SPONSORED BY THE LAMAR ROTARY CLUBS, THE MASTER TEACHER, INC. AND LAMAR COMMUNITY COLLEGE. I ACCEPT RESPONSIBILITY FOR THE FULL PAYMENT OF SUCH MEDICAL TREATMENT. I HEREBY HOLD THE LAMAR ROTARY CLUBS, THE MASTER TEACHER, INC. AND LAMAR COMMUNITY COLLEGE AND ITS REPRESENTATIVES HARMLESS IN THE EXERCISE OF THIS AUTHORITY.

**SIGNATURE OF PARENT OR GUARDIAN:** \_\_\_\_\_