East Chop Yacht Club

EAST CHOP - P.O. BOX 525
OAK BLUFFS, MA. 02557

Medical Information and Emergency Treatment Authorization

Minor child's name: _____

Address: _____

_____

Day-Time Phone to use for emergencies: _____

Local Physician : _____ **Phone:** _____

MEDICAL NEEDS: It is important to know if your child has any special medical needs (such as allergies, sun sensitivity, other) or fears. Please describe.

_____

_____

_____

TREATMENT AUTHORIZATION: I/we, the undersigned parent, parents or legal guardian(s) of the minor named above do hereby authorize and consent to such medical or dental treatment, services or care that is necessary or appropriate in the event of emergency, including the selection of medical personnel and facilities and transportation or transfer to such facilities or in connection with such services and do consent to such corrective or diagnostic surgery as a duly licensed physician and or dentist may determine to be necessary for the life or well-being of the named minor child.

It is understood that reasonable effort will be made to contact me/us prior to rendering any treatment, but that treatment will not be withheld if I/we can not be reached. This authorization is given to provide authority and power to render care which a licensed physician or dentist in the exercise of his/her best judgement may deem urgently required.

Signature (s) of parent, parents, or guardian(s): **Dated:** _____

_____ _____

_____ _____

Name Printed **Name Printed**