COLORADO

FFA Alumni Association

Consent for the Medical Treatment of a Minor

I, the undersigned parent or legal guardian of the minor listed below:

______________________________ ______________ ______________
(Name of Minor, Please Print) (FFA Chapter) (Advisor)

do hereby authorize in advance any necessary medical treatment required for my son/daughter by on- and off-site medical personnel. I also authorize officials to secure the use of and treatment by a ground or air ambulance, if necessary, for transporting my child to the primary or definitive care center.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor and said physician or dentist to exercise his/her best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment.

If the above arrangement is not satisfactory, what would you like for us to do with your child in case he/she is injured or becomes seriously ill? Please attach a sheet with specific directions for emergency care.

I also authorize release of hospital records concerning the diagnosis, treatment, and prognosis to the Colorado FFA Alumni Association or its agents. I understand these records will be used for insurance purposes only.

I agree not to hold the Colorado FFA Alumni Association, the Colorado FFA Association, the State Board for Community Colleges and Occupational Education, the Rocky Mountain Farmers' Union or any agent of these organizations liable for any accident, illness, or injury to my son/daughter while participating in the Chapter Officer Leadership Training Camp, including travel to and from the site.

In the event of an emergency, it is imperative that medical personnel have access to your child's medical history in order to properly evaluate and treat your child. **The following information will be kept confidential by the medical staff on site and released only to medical personnel treating your child.**

Prescribed Medications:

____

Allergies to foods, medications or environmental conditions (bee stings, for example):

____

Does your child have any existing medical conditions that may affect his/her care? If so, list them below.

____

Minor's Social Security Number: ____________________ Minor's Date of Birth: ______________________________

Insurance Company: ____

Policy Holder: ____

Policy Number: ____________________________________ Group Number: __________________________________

Guardian's Address: ____

Guardian's Home Phone: _______________ Work Phone: ____________________ Cell Phone: _________________

Signed ______________________________ ______________
(Signature of Legal Guardian) (Date)

______________________________ ______________
(Please Print Name of Guardian) (Relationship)

FOR STAFF USE ONLY!

Cabin: __________________ Bed Number: __________