

MEDICAL TREATMENT AUTHORIZATION FOR PARTICIPATING MINOR

Name of Minor – Please Print: _____

I represent and warrant to **Rebuilding Together North Suburban Chicago** that I am the parent or legal guardian of the minor named above. The above named minor has my permission to participate in **Rebuilding Together North Suburban Chicago** project. On behalf of such minor and myself, I signed a Volunteer’s Agreement and Release from Liability (the “Release”) and hereby agree to all of the terms and conditions of the Release.

In case of medical or dental emergency, I request that **Rebuilding Together North Suburban Chicago** attempt to contact me at the telephone number set forth below. However, I hereby give permission to the physician or dentist selected by **Rebuilding Together North Suburban Chicago** to hospitalize, treat, secure proper treatment for, and order injection, anesthesia or surgery for the minor named above. A copy of the permission form may be accepted by and treated by the physician or dentist as equivalent to the original permission form.

Medical Insurance Carrier: _____

Policy Number: _____

Family Doctor: _____

Address: _____

Phone: _____

Note the following allergies or limitations on activities:

If I cannot be reached, please contact:

Name: _____ Phone: _____

Printed Name of Parent/ Guardian: _____

Phone: _____

Signature: _____ **Date:** _____