



**AUTHORIZATION TO CONSENT
TO MEDICAL TREATMENT FOR MINOR**

**Please note: This authorization is only valid from
September 1st, 2011 to August 31, 2012 inclusive.**

I (we) _____ and _____ of the
City of _____, in the County of _____, in the State
of _____, do hereby attest that I am (we are) the natural parent(s) or legal guardian(s) having legal
custody of _____, a Minor, age _____, Born, on the date
of _____ 19 _____, Social Security Number, if applicable: _____,
who resides at the address of: _____.

In connection with my (our) child's participation on the _____ Rugby Club of
Hawaii Youth Rugby, I (we) authorize Hawaii Youth Rugby or the Team to consent to any X-ray examination,
any anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and to
be rendered under, the general or special supervision of any physician or surgeon, whether such diagnosis or
treatment is rendered at the office of the physician, or at a hospital. It is understood that this authorization is given
in advance of any specific diagnosis, treatment, or hospital care being required, and is being given to provide
Hawaii Youth Rugby or the team the ability to give specific consent to any and all such diagnosis, treatment, or
hospital care with the aforementioned physician in the exercise of his/her best judgment may deem advisable.
This consent is given with the understanding that the need for treatment is immediate and I (we) am not available.
I (we) understand that I (we) assume all liabilities and expenses for the above. I (we) waive all claims against the
above referred to adult, physicians, hospitals and their employees, ambulatory care, etc., in connection with the
decision for immediate care.

The following is provided: Home phone: _____ Work Phone: _____
Medical Alert: Allergies: _____, Medications: _____
Drug Reactions: _____
Previous Injuries/Illnesses/Surgery: _____
Current Physical Condition: _____
Insurance Provider & Policy Number: _____
Name of Policy Holder (generally the parent): _____
Name of Primary Physician: _____ Phone # _____
Alternate point of contact - Name: _____ Phone #: _____

Sign by Parent/Legal Guardian _____ Date: _____

OR Signature of Minor _____ Date: _____

****Non-minors and emancipated minors must still fill out this form and sign for themselves.****

If you are a High School Senior please check box. []