



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

I (we) \_\_\_\_\_ and \_\_\_\_\_  
of the city of \_\_\_\_\_, in the county of \_\_\_\_\_, state of \_\_\_\_\_  
do hereby state that I am (we are) the natural parent(s) (legal guardian(s)) having  
legal custody of \_\_\_\_\_,  
Social Security Number: \_\_\_\_\_, a minor, age \_\_\_\_\_, Born,  
\_\_\_\_\_ 19 \_\_\_\_\_, who resides at: \_\_\_\_\_.

In connection with my (our) child's participation on the \_\_\_\_\_ Team 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.

**This authorization is only valid from January 1<sup>st</sup>, 2010 to December 31, 2010 inclusive.**

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: \_\_\_\_\_**

**\*\*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. [ ]**