

# Consent to Treat Form



## Authorization and Consent for Health Care

The National Center for Outdoor & Adventure Education (NCOAE) has the right to give first aid to:

(Participant's name): \_\_\_\_\_

and to engage the service of a physician, emergency room and dentist, or to hospitalize if it deems necessary.

I further authorize NCOAE as my or the youth's representative in signing consent for necessary clinical or surgical procedures when he/she is not able to do so. In the event of an emergency I will be notified immediately.

The cost of such service shall be charged to the participant or parent/guardian and paid by the participant or parent/guardian.

## Medical Insurance

Insurance Provider:

Insurance Policy/Group #:

Name of Medication	Dosage	How many times a day?	Reason

## Allergies

Please describe any allergies to medications, foods, plants or insects:

## Participant's Full Legal Name

First Name:

Last Name:

## Parent or Guardian's Full Name

First Name:

Last Name:

Signature:

Date: