

**REBUILDING TOGETHER PENINSULA
MEDICAL TREATMENT AUTHORIZATION
FOR PARTICIPATING MINOR**

(Must be accompanied by Volunteer Release form signed by parent or guardian)

Name of minor: _____ Date of Birth: _____

Address: _____

Parent or Guardian Contact Info: _____

By my signature below, I represent and warrant to Rebuilding Together Peninsula (“RTP”) that I am the parent or legal guardian of the minor named above. The above-named minor has my permission to participate in the Rebuilding Together Peninsula Project (the “Project”). **On behalf of such minor and myself, I have signed a Volunteer Agreement, Assumption of Risk and Release of 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 RTP contact me at the telephone number set forth below. However, I hereby give permission to the physician or dentist selected by RTP to hospitalize, treat, secure treatment for, and order injections, anesthesia, X-ray examinations or surgery for the minor named above. A copy of this form may be accepted by and treated by the physician or dentist as the equivalent of the original form.

_____	_____	(____)_____
Date	Signature of Parent/Guardian	Telephone

Address of Parent/Guardian, if different from address of minor

PLEASE COMPLETE THE FOLLOWING:

1. Medical Insurance Carrier: _____
Policy Number: _____
2. Family Doctor: _____
Address: _____
Telephone: (____)_____
3. Family Dentist/Orthodontist: _____
Address: _____
Telephone: (____)_____
4. Drug or food allergies: _____
5. Limitation on activities: _____
6. If I cannot be reached, please contact: _____
Telephone: (____)_____