THE CASTLEMAN QUARTET PROGRAM
MEDICAL TREATMENT AUTHORIZATION & CONSENT FORM

(FOR PARTICIPANTS UNDER 18 YEARS OF AGE)

Name of minor _____

Address _____

City/ST/Zip _____

Birthdate of minor _____

Effective June 3 – July 22, 2018, the undersigned do hereby authorize The Castleman Quartet Program or such substitute as they may designate as agent for the Undersigned to consent to any Xray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. *If the attending medical professional believes there is sufficient time before treatment must commence, every effort will be made to contact me.*

_____ _____

Parent/Guardian Signature *Date*

Parent/Guardian Name (print) _____

Parent/Guardian Address _____

_____

_____ _____ _____

HOME phone *CELL phone* *WORK phone*

Insurance Co. _____ Policy No. _____

Blood Type _____ Current Medication _____

Illnesses or Allergies _____

_____

Family Physician _____

Family Physician Address _____

Family Physician Phone _____

➤ *Please include a copy of your Insurance ID Card with this form* ➤