



**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 July 22 – August 12, 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* ◀