

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

I, (WE) \_\_\_\_\_ and \_\_\_\_\_ are the parent (s) or legal guardian(s) of

Minor & age \_\_\_\_\_

Minor & age \_\_\_\_\_

Minor & age \_\_\_\_\_

Minor & age \_\_\_\_\_

Minor & age \_\_\_\_\_

I, (We) authorize a representative of the Village of Warsaw and River View Community Pool to consent to any necessary examination, anesthetic, medical diagnosis, surgery or supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Account Number : \_\_\_\_\_

MEDICAL HISTORY:

Allergies, if any, including medicine: \_\_\_\_\_

\_\_\_\_\_

Chronic or existing diseases or medical problems \_\_\_\_\_

\_\_\_\_\_

Medicines your child is taking now: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

**Please return with membership application**