TOWN OF ALPINE
PARKS & RECREATION DEPARTMENT

CHILD AUTHORIZATION FOR TREATMENT

Family's Last Name of Child (ren) _____ Expiration Date _____

1. _____ (Child's Full Name) _____ Date of Birth _____ Medical Information (Allergies, Medications)

2. _____ (Child's Full Name) _____ Date of Birth _____ Medical Information (Allergies, Medications)

3. _____ (Child's Full Name) _____ Date of Birth _____ Medical Information (Allergies, Medications)

4. _____ (Child's Full Name) _____ Date of Birth _____ Medical Information (Allergies, Medications)

IN CASE OF EMERGENCY CONTACT:

_____ (Parent or Guardian's Full Name) _____ Home Phone _____ Work Phone or Cell # _____ Social Security Number

_____ (Mailing Address _____ City _____ State _____ Zip

_____ (Parent or Guardian's Full Name) _____ Home Phone _____ Work Phone or Cell # _____ Social Security Number

_____ (Mailing Address _____ City _____ State _____ Zip

_____ (Full Name) _____ Relationship to Child(ren) _____ Phone Number _____ Work/ Cell Phone #

_____ (Full Name) _____ Relationship to Child(ren) _____ Phone Number _____ Work/ Cell Phone #

FOR HOSPITAL BILLING PURPOSES

INSURANCE COMPANY:_____
INSURANCE COMPANY MAILING ADDRESS AND PHONE #:_____
_____
PRIMARY INSURED'S NAME:_____
I.D. OR POLICY NUMBER:_____
GROUP NAME:_____ **GROUP #:**_____

I understand and agree that I am responsible for any and all costs and expenses for emergency care and/or medical care or treatment rendered to the above named minor(s) for whom I am legally responsible for. The authorization shall remain in Force until the above noted expiration date or until personally revoked in writing by the undersigned, if sooner.

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Witness Signature **Date**