MINOR'S MEDICAL AUTHORIZATION FORM

_____(Participant's Name) has my permission to participate in the 2018 Annual Olustee Battle Reenactment, sponsored by the Olustee Battlefield Citizens Support Organization, the Florida Park Service, and the U.S.D.A. Forest Service.

I understand that participants must be at least 16 years of age in order to participate in the Olustee Battle activities with a black powder weapon. I understand in the event my child under the age of 16 is found to be in possession of black powder or a black powder weapon, they, along with their entire unit will be immediately dismissed from all Olustee Battle activities.

In my absence or in the absence of an authorized parent or guardian of the participant, I hereby authorize the Unit Commander or his representative of the _____(Unit's Name) to administer first aid and to obtain and consent on behalf of the Participant and Participant's parents or guardians, any emergency first aid or medical care by any physician, hospital, or attendant as a result of involvement in the Reenactment activities. I agree to abide and be bound by such decisions and consents as if made by me and do assume full financial responsibility for agree to pay all expenses of such care. I understand that it is my responsibility to secure adequate insurance for first aid and medical care.

The name of our health insurance is: _____

Policy Number_____

I further authorize any physician, hospital, or medical attendant to receive full and complete medical reports or information deemed necessary by them with respect to the treatment of my child. Execution of this document shall operate as an authorization for such person(s) to receive any medical information which they require.

The medical authorization contained within this form shall be valid and usable by the participant's Unit Commander or his designee during the Olustee Battle Reenactment activities, February 15, 16, 17, 18 and 19, 2018 at the Olustee Battlefield Historic State Park and this authorization shall remain valid unless revoked by me in writing.

_____ _____

Signature of Parent or Guardian Date

SWORN TO AND SUBSCRIBED before me this _____day of _____,_____

_____

Notary Public

_____Personally Known To Me
_____Produced As Identification

_____

Type of Identification

MEDICAL INFORMATION

The following information will enable us to better protect your minor child's health and safety:

Child's Name:_____

Your Name:_____ Relation: _____

Address: _____
(include city, state and zip code)

Telephone:_____ Work Phone _____

PERSONS TO CONTACT IN CASE OF AN EMERGENCY-<u>If I cannot be reached first:</u>
Name:_____ Phone:_____

Address:_____
(include city, state and zip code)

Name:_____ Phone:_____

Address:_____
(include city, state and zip code)

Does your child have any disabilities that we should be aware of? Yes___No___

If YES, please explain_____

Does your child have MEDICAL PROBLEMS of which WE NEED TO AWARE? Yes____ NO____

If YES, please explain_____

Is your child currently taking ANY MEDICATIONS? Yes____ No____

Name (s) of Medications?_____

List of ALLERGIES_____

FAMILY PHYSICIAN_____ PHONE_____

Date_____ Parent/Guardian Signature_____