

**MINOR'S MEDICAL AUTHORIZATION FORM**

\_\_\_\_\_ (Participant's Name) has my permission to participate in the 2008 Annual Olustee Battle Reenactment, sponsored by the Olustee Battlefield Citizens Support Organization, the Florida Park Service, and the U.S.D.A. Forest Service.

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 14, 15, 16, 17 and 18, 2008 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-If I cannot be reached first:**

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 \_\_\_\_\_