

CONSENT TO TREAT MINOR CHILDREN -PVFA

Please print all information:

With respect to the minor individual, _____,

born _____ (D.o.B.), I, _____,

do hereby consent to **the evaluation for and application of medical care to the minor individual which has been deemed necessary by a medical professional** while they are under the care of a representative of Pioneer Valley Fencing Academy (94 Cottage St, Easthampton, MA 01027; "PVFA"). This is to specifically include consent to the following:

- the application of simple First Aid by a representative of PVFA while on the premises of PVFA;
- the transportation of the minor to the nearest urgent care facility, Cooley Dickinson Urgent Care (12 College Hwy, Southamptn, MA 01073), by a representative of PVFA and the subsequent treatment of said minor by said facility; and/or
- the transportation of the minor to the nearest hospital facility, Cooley Dickinson Hospital (30 Locust St, Northampton, MA 01060), by a representative of PVFA or by ambulance, as necessary, and the subsequent treatment of said minor by said facility.

I acknowledge and accept that any cost incurred for medical treatment will be solely my responsibility and not the responsibility of Pioneer Valley Fencing Academy or any representative of Pioneer Valley Fencing Academy (ex: coaches, assistant coaches, etc.).

This authorization is effective from _____ to _____ (18th birthdate).

The Contact information to be attempted by a representative of PVFA is as follows:

Primary Phone: _____ [] Call / VM [] Text Message

Alternate Phone: _____ [] Call / VM [] Text Message

Signature of Parent and/or Legal Guardian:

_____ **Date** _____

Parent and/or Legal Guardian (please print): _____

Signature of Witness:

_____ **Date** _____

Name of Witness (please print): _____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

ADDITIONAL INFORMATION: Any information provided below will only be used to assist with treatment. It is not required as a condition of consent:

1. Parent and/or Legal Guardian: _____

Primary Phone: _____ [] Call / VM [] Text Message

Alternate Phone: _____ [] Call / VM [] Text Message

Relationship to minor: _____

2. Parent and/or Legal Guardian: _____

Primary Phone: _____ [] Call / VM [] Text Message

Alternate Phone: _____ [] Call / VM [] Text Message

Relationship to minor: _____

Other Pertinent Information:

Known Allergies (drugs or food): _____

Special Medications: _____

Last Tetanus Vaccination: _____

Blood Type: _____

Residential address: _____

Minor's Primary Care Physician: _____

Phone: _____

Guardian's Health Insurance Provider: _____ Policy # _____

Additional Notes: _____
