

**2011 AVA VAULTING CAMP - Fort Robinson, NE**

**AUTHORIZATION AND CONSENT TO TREATMENT**

**MUST BE COMPLETED AND SIGNED BY ALL VAULTERS (PARENTS MUST ALSO SIGN FOR MINORS), LONGEURS, COACHES, TRAINERS, AND HORSE OWNERS.**

(I) (we), the undersigned, or parent(s) or legal guardian(s) of the minor listed below, do hereby authorize AVA Emergency Medical Technician, as agent(s) for the undersigned, to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of my (our) aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

Print Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Health Insurance Company \_\_\_\_\_

Health Ins. Policy Number: \_\_\_\_\_

Print Parent's or Legal Guardian's Names (if participant is minor)

Print Street  
Address \_\_\_\_\_

City State Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Please list all known allergies or sensitivities to medications, etc.:

\_\_\_\_\_  
List any other allergies:

\_\_\_\_\_  
List any medications minor possesses for use daily or as necessary:

\_\_\_\_\_  
Describe any other pertinent medical conditions or information, which may be needed. Include information regarding medical insurance.

\_\_\_\_\_  
Date of most recent tetanus shot: \_\_\_\_\_

Signature of participant or parent(s) or guardian(s) of minor

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