

**“Throw for OFO” Medical Information & Consent Form**

Participants Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone \_\_\_\_\_ Birthdate \_\_\_\_\_

**Medical Information**

Any medical restrictions/problems concerning participant named above?

\_\_\_\_\_

Any allergies or medications being taken?

\_\_\_\_\_

**Consent for Medical Treatment (Minor)**

As the parent or legal guardian of the above named participant, I hereby give my consent for emergency medical care prescribed by a duly licenses Doctor of Medicine or Doctor or Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent. Please accept one of the parties name below as having received my permission to authorize medical treatment for my children my absence:

Authorized Contacts for Medical Treatment:

1. \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/legal guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

