YOUTH WORKSHOP WAIVER/MEDICAL AUTHORIZATION

THE Mediation mentor®

1. **AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS** - I authorize minor medical treatment, such as ice packs, Band Aids, etc., and grant parental permission as allowed under the law, for provision of emergency medical, dental, and hospital services. In such cases, this form acts as a legal document giving permission for an authorized THE MEDIATION MENTOR representative to authorize treatment in your absence. However, a child may be treated without parental consent when a physician determines the child needs immediate medical care and that any attempt to obtain parental consent would result in a delay which would increase the risk to the child's health or life. Finally, I accept full financial responsibility, for all costs, charges, and fees associated with the transportation of my child and for the treatment provided by the medical care facility to my child and absolutely and unconditionally agree to indemnify and to hold THE MEDIATION MENTOR harmless from all such costs, charges, and fees.

Parent/Legal Guardian Initials ____________________

2. **ALLERGIES** – Please list any allergies (food, insect, environmental) your child may have. When in doubt, please list.

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Does your child require an EpiPen? __________ Does your child require an inhaler? ____________

3. List any factor(s) that makes it advisable for your child to follow a limited program of physical activity. (e.g.: heart condition, recent fractures, surgery, asthma, extreme fears, etc.) ____________

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4. Will your child need any medications administered during the workshop? ___________________
If so, please provide the complete name, dosage, and directions for each medicine below.

ALL WORKSHOP ATTENDEES MUST BE ABLE TO SELF-MEDICATE OR PROVIDE A DOCTOR'S NOTE FOR ALL MEDICATIONS

MEDICATION	DOSAGE	INSTRUCTIONS

Physician's Name: _______________________________________**Phone:** ________________
Please read and initial consent to the following:
________ I give permission for my child to self-administer his/her inhaler.
________ I give permission for my child to self-administer his/her EpiPen as prescribed by a physician.
Parent/Legal Guardian Signature: ____
Date: ______________________

Child's Name: ____ **DOB:** ____________________