



The Boys To Men Mentoring Network of Minnesota

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Websites: National: www.BoysToMen.org Local: www.BoysToMenMN.org/

Consent for Medical Treatment for Minor Child

Boys name: _____
Boy's birth date: _____
Parent or Guardian name: _____
Home phone number: _____
Work phone number: _____
Other phone number: _____
Primary care physician: _____
Physician's phone number: _____
Clinic name: _____
Clinic phone number: _____
Medical insurance company: _____
Medical policy number: _____

I hereby give my permission for my child to receive the following medication(s) at the Boys to Men Rites of Passage Adventure Weekend as prescribed by my child's physician. I understand that my signature gives permission to the staff to administer this medication.

Medication: _____
Dosage: _____ mg/ml
Time: _____

Medication: _____
Dosage: _____ mg/ml
Time: _____

Please list any other medical concerns or restrictions your child may have:

I hereby certify that my son is in proper health to participate in camp activities. In the event of a medical emergency, I understand that every attempt will be made to notify me immediately. If for any reason I am unable to be reached at the numbers provided, I authorize the Boys to Men staff to act on my behalf with regards to providing necessary emergency medical care for my child.

Parent/Guardian Signature: _____

Parent's name printed: _____

Date signed: _____