



The BOYS TO MEN Mentoring Network – Minnesota

Local: boystomenmn.org National: boystomen.org mentoring@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: _____