MEDICAL AUTHORIZATION The O foundation for the Arts

Member Name	
Date of Birth	
Street Address	
City	
State	
Zip	
Home Phone	
Cell Phone	
Emergency Contact #	
Relationship to Member?	
Allergies	
Prescription Medications	
OTC Medication	
Health Conditions	

List additional health or physical condition/concerns/situations you want the staff to be aware of:

I, _____, hereby give my consent for a qualified physician or surgeon to examine, diagnose, prescribe, and perform treatment, including surgery that he/she deems advisable for the welfare of individual listed above. I also give my consent for the transportation of named individual to any accessible medical facility.

Member Name_____

Member Signature_____ Date_____

Parent or Guardian Name_____

Parent or Guardian Signature_____ Date_____

Parent or Guardian Contact Number_____