

**Authorization for Emergency Medical Treatment
International Order of the Rainbow for Girls
Grand Assembly of Maine**

I, _____ (Parent or Legal Guardian) of _____
_____ (Street Address)
_____ (city/town, state) am the father / mother / legal guardian (circle one) of
_____ (girl's name). Her date of birth is _____.

She is a member of _____ Assembly # _____ of the International Order of the
Rainbow for Girls.

I do hereby give my consent and authorize, in the event that all reasonable attempts to contact me at
_____ (list all phone numbers) have been unsuccessful for the
following:

- 1) The administration of X-ray examination, medical diagnosis or treatment and hospital care deemed necessary by a licensed physician or dentist.
- 2) The transfer and admission for care to any reasonable accessible hospital.

The following information is needed by any hospital or practitioner.

Allergies: _____

Medications currently being taken (including all prescriptions and any over the counter medications): _____

Any Physical impairment? _____

Date of last tetanus shot if known _____

Any other pertinent information which a physician should be alerted to? _____

Name and Phone Number of Family Physician _____

Name, address & Policy number of your medical insurance carrier (or attach a copy of your card) _____

I also give my permission for a nurse or an appropriate adult chaperone to administer (2) Tylenol or ibuprofen tablets to my child.

| | | |
|---------------|-----|----|
| (2) Tylenol | yes | no |
| (2) Ibuprofen | yes | no |

Signature of Parent / Guardian _____ Date _____

Signature of Member (if over 18) _____ Date _____

