PATH: Preserving, Archiving & Teaching Hiphop, Inc. / info@pathtohiphop.org / www.pathtohiphop.org / 786.338.3544

MEDICAL AUTHORIZATION FORM

I, _____, hereby authorize
Parent/Guardian Name
PATH: Preserving, Archiving & Teaching Hiphop, Inc. to initiate the rendering of medical care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by medical doctors, hospitals or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care of my child,

_____.
Child's Name
This authorization shall remain in effect from July 1, 2016 until July 1, 2017.

ALLERGIES: _____

_____BLOOD TYPE:_____

MEDICATIONS/DOSAGE: _____

_____

MEDICAL INSURANCE COMPANY: _____

MEDICAL INSURANCE ID or GROUP #:_____

MEDICAL INSURANCE CO. PHONE #:_____

_____
Physician Name Phone

_____
Physician Address Preferred Hospital

_____
Parent/Guardian Signature Date

_____
E-mail Phone