



**EMERGENCY CONTACT INFORMATION AND AUTHORIZATION OF MEDICAL TREATMENT**

In the event of an emergency we will make every attempt contact you and contact persons you authorize.

Father's Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address (If different): \_\_\_\_\_

Other authorized person: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

In the event of an emergency, the following has my permission to pick up my child(ren) without notice:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

I, \_\_\_\_\_ hereby give permission to the CFD Old West Museum to obtain medical or surgical care from a health care facility, physicians, or dentists for my child, whose full name is \_\_\_\_\_, should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians /dentists may be taken. I further consent to transportation of the above named child to the nearest or most appropriate medical facility by a museum staff member.

Childs Primary Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Childs Primary Dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

The medical insurance company that covers the above named child is:

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

**PARENTAL RELEASE**

In consideration of accepting my son'(s)/daughter'(s) registration for the CFD™ Old West Museum 2010 Summer Camps, the risks of which I am aware, I hereby waive, release, and discharge for myself, my family members, heirs, personal representatives and assigns any and all rights and claims for damages against the CFD™ Old West Museum, it's employees, volunteers, and agents which might occur during my son'(s)/daughter'(s) participation in such activity.

Signature of Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_