

MEDICAL AUTHORIZATION FORM CONSENT TO TREAT MINORS

The undersigned, being the parent(s) or legal guardian(s) of _____
(a minor), do hereby appoint Royal Freas, Sailing Director of Galveston BASE, or his assigns,
to act in my (our) behalf in authorizing emergency medical, dental, or surgical care and
hospitalization for the above named minor during a period of my (our) absence June 15– 20
2008

This document shall be presented to a physician, dentist, or appropriate hospital representative
at such time as emergency medical, dental, surgical care, or hospitalization may be required.
Where no proof of insurance is established, parent(s) or guardian(s) of member must assume
legal responsibilities for expenses incurred for the treatment of injuries to member that occur
during this period of Galveston BASE.

Signature Parent/Guardian Date

Signature Parent/Guardian Date

Address

Address

City State Zip

City State Zip

Phone

Phone

Witness Date

Witness Date

Hospitalization Coverage for Named Minor

Insurance Waiver Statement

Name of Insurance Co. or Carrier

Where no proof of insurance is
established, parent(s) or guardian(s) of
member must assume legal
responsibilities for expenses incurred
for the medical treatment of injuries to
member that occur at Galveston BASE
and understand the above.

Identification or Contract Number

Parent Signature Date

Family Physician and Phone

Member's Name (minor)