EMERGENCY MEDICAL TREATMENT
(PARENT CONSENT FORM).

I, _____
(Parent/Guardian's Name) (Relationship)

Of _____
(Name of TSA Participant) (Age)

Complete Home Address: _____

(including Zip) _____

_____

(Area code and Home telephone No.) _____

(Area code and Work telephone No.) _____

hereby authorize in advance any necessary medical treatment required while he/she is attending a TSA activity.

Medical/hospitalization carrier policy number: _____

Other Medical Insurance: _____

Policy Number: _____

_____
(Signature)

_____
(Date)

NOTE: **Chapter Advisors are to keep this original and SEND A PHOTOCOPY of the completed form to DOE.**