Club Rust

Authorization for Treatment of a Minor

*All personal information submitted on this form will be kept strictly confidential. Please **print** in **block letters**.*

MINOR'S FULL NAME	DATE

I, _____ , being the parent or legal guardian of _____ hereby give my consent for emergency medical and/or surgical treatment of this minor in a local hospital/medical facility by a physician should his/her condition so require it in my absence. I understand that in such a case, time and conditions permitting, reasonable attempts would first be made to contact me. When applicable, I authorize CLUB RUST organizers (George Saba, Susan Saba, and/or any other CLUB RUST adult organizers) to administer medications both those prescribed prior to the trip and any deemed necessary by a medical doctor during the trip. I impose no specific limitation or prohibitions other than those that follow:

(If none, state so by writing "none" on the line below)

_____

THIS AUTHORIZATION IS EFFECTIVE FOR THE FOLLOWING TIME PERIOD: (Please handwrite in dates)

From: ____ / ____ / ____ **To:** ____ / ____ / ____

Month / Day / Year — Month / Day / Year

SIGNATURE OF FATHER OR LEGAL GUARDIAN		SIGNATURE OF MOTHER OR LEGAL GUARDIAN	
PRINT FULL NAME OF FATHER OR LEGAL GUARDIAN		PRINT FULL NAME OF MOTHER OR LEGAL GUARDIAN	
FATHER'S WORK PHONE	FATHER'S CELL / OTHER PHONE	MOTHER'S WORK PHONE	MOTHER'S CELL / OTHER PHONE
ALTERNATE EMERGENCY CONTACT PERSON		RELATIONSHIP TO FAMILY	ALTERNATE PHONE NUMBER

Complete, Print, Sign and Mail this one page waiver form to: CLUB RUST 9008 LINDEN AVE N SEATTLE WA 98103-3946