AUTHORIZATION FOR FIRST AID AND MEDICAL TREATMENT

I recognize that medical or dental care may be necessary for myself and/or my minor child. I AUTHORIZE Two Wheel View (TWV) and THE TRIP LEADER(S) TO RENDER FIRST AID OR EMERGENCY CARE, within the scope of the certification of the trip leader(s). In addition, I authorize TWV to call for medical or dental care for myself and/or my minor child if, in the opinion of TWV, medical or dental care is needed. I AGREE TO PAY FOR ALL EXPENSES AND COSTS ASSOCIATED WITH SUCH CARE AND RELATED TRANSPORTATION. In addition, I hereby authorize and consent for any x-ray examination, anesthetic, medical, dental or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and/or emergency staff and/or dentist currently licensed by the state in which treatment is given and the staff of any acute general hospital holding a current license to operate a hospital from the Department of Public Health or the equivalent agency in another state or country. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the physician in the exercise of his best judgment may deem advisable. It is understood, medical condition allowing, that effort shall be made to consult the undersigned prior to rendering the treatment to the patient, but that any of the above treatment will not be withheld if the undersigned is incapacitated or cannot be reached.

_____

[NAME OF PARTICIPANT] [AGE] [NAME OF PARENT/GUARDIAN OF MINOR PARTICIPANT]

_____

[SIGNATURE OF PARTICIPANT OR PARENT/GUARDIAN OF MINOR PARTICIPANT] [DATE]

PARTICIPANT'S EMERGENCY MEDICAL INFORMATION

1. Participant's Name_____

Parent's/Guardian's Name (of minor participant)_____

Address:_____

Phone: _____ Birthdate: _____ Date of most recent tetanus toxoid booster:_____

2. Allergies to drugs, foods, insect bites, etc.:_____

_____

_____

3. List all medications for which the participant currently holds a prescription and indicate which ones the participant will be taking during trip(s):

_____

_____

4. List all medical conditions of which the trip leader should be aware or which may affect the participant's ability to participate in activities (such as asthma, heart disease, diabetes or neuromuscular or skeletal impairment):

_____

_____

Family Physician:_____

(Name) (Address) (Phone)

Insurance Company: _____ Policy Number_____

List the persons we should call in case of an emergency. We will try to contact them in the order that they are listed below.

1. _____

Name Relationship Daytime Phone Evening Phone

2. _____

Name Relationship Daytime Phone Evening Phone

Send completed form to TWO WHEEL VIEW
USA: PO Box 40084 - St. Paul, MN 55104
CANADA: #207, 223 - 12th Ave SW - Calgary, AB T2R 0G9