

Authorization for the Medical Treatment of Minors

Boy's Gymnastic Team Competition

Names of Minors	Birthdate	Identify Allergies or Special Conditions				
I/we, being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:						
Name Shawn Clement	Address 4766 Sidney St. Shelby Twp, MI 48317	Phone (248) 321-7742				
Name Curtis Wilson	Address 17016 Juliana, East Pointe, MI 48021	Phone (586) 776-4344				
Name Julie Maurer	Address 225 Schorn, Lake Orion, MI 48362	Phone (248) 830 7270				
To act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:						
Month November	Day 1	Year 2006	Through	Month November	Day 1	Year 2007
In no event shall this delegation of parental rights be effective for more than 1 year. This document shall be presented to a physician, dentist or appropriate hospital representative at such time as medical, dental surgical care or hospitalization may be required.						
Parent/ Guardian			Parent/ Guardian			
Signature			Signature			
Address		Date	Address		Date	
Witness (Notary Public)			Seal			
Signature			County			
Address			Expiration Date			
Hospitalization Coverage for Above Named Minor(s):						
Insurance Company or Government Program			I.D. or Contract Number			
Family Physicians:						
Name and phone Number			Name and phone Number			