YOUNG MARINES OF THE MARINE CORPS LEAGUE
WASHINGTON DC

Young Marines
Authorization for Medical Treatment
PLEASE PRINT (*Update for each event requiring medication*)

Last Name _____First Name _____Middle Initial_____

Age _____ Date of Birth ___/____/____Social Security Number_____

Home Street Address _____ City _____ State___ Zip Code _____

Parent/Guardian Name _____ Relationship _____

Home Street Address _____ City _____ State___ Zip Code _____

Home Telephone Number (____)_____ Work Telephone Number (____)_____

Mobile Number (____)_____Pager Number (____)_____Other Number (_____)_____

PART I: Medical Consent (*Parent or Legal Guardian is required to complete*)

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize that my child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary. *(Please attach front & back photocopy of Medical Insurance Card)*
Name of Medical Insurance Company _____
Medical Insurance Policy No. _____
Insurance Company Contact Telephone Numbers (____)_____/(____)_____

Parent or Legal Guardian _____ Date _____

PART II: Permission to Use Over-the-Counter Drugs (*If not completed, Young Marines will not receive medication*)

My child, _____, has my permission to take any over-the-counter medications in accordance with label instructions as needed with the exception of:

_____
_____
while attending Young Marine Activities.

Parent or Legal Guardian _____ Date _____

PART III: Permission to Dispense Prescription Drugs (*If not completed, Young Marines will not receive medication*)

I request and authorize that my child, _____, be administered the following prescription medication:

_____
_____
per the medical doctor's instructions on the original and un-expired pharmacy label. I certify that my child has a valid health reason for taking the medication during the Young Marine Activities. This permission is valid from (beginning date)_____ to (ending date) _____.

Parent or Legal Guardian _____ Date _____

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PART IV: Medication Administration Record (*A PART IV is required for each Prescription or Over-the-Counter Medication*)

Last Name _____First Name _____Middle Initial_____

Age _____ Date of Birth ___/____/____Social Security Number_____

Medication Name _____ Strength _____
Type of Medication Form: ____ Liquid ____ Tablet ____Aerosol ____Ointment ____ Other
Dosage & Time _____

Date	Time	Dose	AMO 1 Signature	AMO 2 Signature	Remarks