Olive Plants Co-op

Emergency Contact and Authorization for Medical Treatment

I, _______________________________ *(parent or legal guardian's name)*,
am the parent or legal guardian of ____
(name of minor child(ren) ,
who is/are attending and participating in Olive Plants Homeschool Co-op .
I hereby authorize Olive Plants Co-op (*otherwise referred to as OP Co-op*) and its officers, agents, volunteers, instructors, or supervising parents to seek emergency medical care and/or emergency dental care for my child. I further authorize OP Co-op and its officers, agents, volunteers, Instructors, or supervising parent, to receive physical custody of my child upon completion of treatment. I understand that this Authorization for Medical Treatment is ONLY to be used in the case of an extreme emergency when I, the parent/legal guardian of my child(ren), am unavailable or cannot be reached by phone OR the timeliness of medical care warrants immediate action. If treatment immediate medical treatment is warranted, the listed legal guardian will be contacted as soon as your child's immediate needs are met.

Address: city/state/zip ***Date:***

____ ______________________________

Home phone/Work phone/Cell phone:

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Child(ren)'s Primary Care Doctor & Phone Number:

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Please list any known medical conditions and allergies, and/or specify any medication or medical devices (e.g. inhaler) that the child(ren) will need to have with him/her at co-op:

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In case of emergency, list another adult and phone number we may contact if you are unavailable:

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Any other medical issues Olive Plants co-op should be aware of?