



*Collegiate Challenge*  
Emergency Contact Information

**Youth Programs department**

**Team Leaders: KEEP THIS FORM WITH YOU AT ALL TIMES! Do NOT return it to the Collegiate Challenge office!**

**Collegiate Challenge Participant:** Thoroughly complete this form and return it to your team leader.

**1 PARTICIPANT INFORMATION**

Full name \_\_\_\_\_

Allergies (medicine, food, etc.) \_\_\_\_\_

Any special dietary needs \_\_\_\_\_

List any medication being taken \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Physical impairments \_\_\_\_\_

Other \_\_\_\_\_

Family physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal code \_\_\_\_\_

Phone (     ) \_\_\_\_\_

Name of insurance carrier \_\_\_\_\_

Phone number of insurance carrier (     ) \_\_\_\_\_ Policy number \_\_\_\_\_

Social Security number of the policy member (i.e. parent) \_\_\_\_\_

**2 IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal code \_\_\_\_\_

Daytime phone (     ) \_\_\_\_\_ Evening phone (     ) \_\_\_\_\_ Cell (     ) \_\_\_\_\_



**Note:** The Campus Chapters and Youth Programs department of Habitat for Humanity International does not require completion of Parental Authorization for Treatment of a Minor Child, but the school faculty member/chaperone of the Collegiate Challenge trip can require the completion by participants under 18 years old.

I, \_\_\_\_\_, am the parent or legal guardian having custody of \_\_\_\_\_, a minor child. As such parent or legal guardian, I hereby authorize and appoint \_\_\_\_\_, an adult in whose care the minor child has been entrusted as my agent to act for me with respect to my minor child, \_\_\_\_\_, from this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and in my name in any way I could act in person to make any and all decisions for me with respect to my minor child, \_\_\_\_\_, concerning my minor child's personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, including X-ray examination, anesthetic, medical or surgical diagnosis or treatment which may be rendered to my minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state in which treatment is sought. My agent shall have the same access to my minor child's medical records that I have, including the right to disclose the contents to others.

Witness \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Witness \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

This Parental Authorization for Treatment of a Minor Child sworn to and subscribed before me by \_\_\_\_\_ and \_\_\_\_\_, the parents or legal guardians of \_\_\_\_\_, a minor child, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_

