

Permission for Medical Treatment

Participant Name: _____

Parent or Guardian: _____

I give permission to the adult supervisors and instructors of the Northwest Indiana Fencing Club to seek and initiate medical treatment for my minor child, or child under my care, in the event that I am not present and that treatment is deemed necessary.

Signature of Parent or Guardian: _____

Emergency Contact Phone # (home) _____ - _____ - _____

(cell) _____ - _____ - _____

Date: _____