Town of Clarence Youth Bureau
10510 Main Street
Clarence, NY 14031
(716) 407-2162

MEDICAL AUTHORIZATION FORM & GENERAL RELEASE

I/We:_____the parent(s) of _____,

age _____, living at _____:

1. Give consent to the Town of Clarence Youth Bureau to arrange for emergency medical care while my son/daughter is under their supervision.

_____ _____
Parent/Guardian Signature Date

Health Insurance Policy Name: _____

Policy Number: _____

Please list any medical information (i.e. allergies, medication, etc.) that we should be aware of: _____

_____

2. Town of Clarence General Release Form – (if applicable) see attached

EMERGENCY INFORMATION

Person(s) to be notified in case of emergency:

Name: _____

Address: _____

Phone #: (home) _____(work)_____(cell) _____

Relationship to child: _____

Name: _____

Address: _____

Phone #: (home) _____(work)_____(cell) _____

Relationship to child: _____