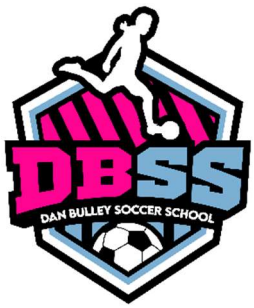

Medical Treatment Authorization/Release

Participant's Name_____ D.O.B _____

1. List any medical conditions that DBSS personnel should be aware of _____

_____

2. List any medications currently taking _____

3. List any allergies _____

In case of an emergency please contact:

Name _____

Cell phone _____

Email Address _____

Daytime phone _____

_____, as parent or legal guardian of the participant named above, authorizes DBSS to seek medical and/or surgical treatment which is reasonably necessary to take care of the participant. I further authorize the medical facility that treats the participant to release all the information needed to complete the insurance claims. I acknowledge my responsibility to pay all costs associated with the participant's medical care and authorize all insurance payments, if any, to be made directly to the medical facility.

_____ _____

Signature (Parent or Guardian) Date