CONSENT TO MEDICAL TREATMENT

STATEMENT REQUIRED BY PRIVACY ACT OF 1974

(1) AUTHORITY: TITLE 10, U.S. CODE 2102.
(2) PRINCIPLE PURPOSE(S): A statement authorizing medical care in civilian or government medical facilities while attending or traveling to or from the Junior ROTC the _____
(title of event, and dates)

_____

(3) ROUTINE USES: Normal personnel actions. Disclosures of information may be provided to proper authorities in actions regarding medical treatment, legal actions as a result of injury or death, and investigation of accident resulting from the Junior ROTC the _____
(title of event, and dates)
(4) MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION: This is a voluntary disclosure. However, failure to complete this form will disqualify the Junior ROTC cadet from participating in the Junior ROTC the _____
title of event, and dates)
.

I, _____, consent to be treated in an Army or civilian hospital, or any other government or
Printed Name of Cadet
civilian medical facility, near or en route to the _____
(title of event, and dates)
_____
This consent encompasses all procedures and treatments as are found to be necessary or desirable, in the judgment of the professional staff of any of the above-named medical facilities. I understand that this consent is of a general nature and accordingly list the following exceptions to this consent (if no exceptions, write "No Exceptions")

_____
_____.

I have the following medical conditions: _____
_____
_____.

I (am) (am not) on medication (List the **type**, **frequency**, and **dosage**, if on medication) _____
_____
_____.

I (am) (am not) allergic to medication (List the **type**, if allergic) _____
_____
_____.

It is understood that this consent can be withdrawn in writing or orally at any time.

_____ _____
Signature of Cadet Printed Name of Cadet

PARENT OR GUARDIAN: (When cadet is a minor or unable to give consent), I, _____,
Parent/guardian of _____, have read and understood the above consent to treatment and hereby expressly consent to the above-described treatment.

_____ _____
Printed Name of Parent Signature of Parent

_____ /_____ _____ / _____
Family Health Plan Carrier/Policy # Home Phone/Work Phone