

Greensboro Police Department Explorer Program

CONSENT FOR MEDICAL TREATMENT

IN EMERGENCY SITUATIONS

I, _____, parent/legal guardian of _____, applicant for Explorer Program, hereby grant Explorer Program Staff the authority to obtain medical treatment when I am unavailable for:

Name of Minor Child _____ DOB _____

The Explorer Program Staff members are authorized to obtain medical treatment and procedures for this child as may be appropriate in medical emergencies situations, including treatment by physicians, hospital and clinic personnel and other appropriate health care providers.

This grant of temporary authority shall begin on _____ and shall remain effective until the minor child's eighteenth birthday or until revocation by the undersigned.

Printed name

Signature

Witness:

I, _____,
a Notary Public of _____
County, North Carolina, certify that

personally appeared before me and
acknowledged the due execution of the
foregoing MUTUAL ASSISTANCE
AGREEMENT.

This the ____ day of _____, 2017.

My commission expires: _____
(Seal)