

**ADULTS**  
**AUTHORIZATION FOR MEDICAL TREATMENT AND RELEASE**  
**NEVADA RAINBOW GIRLS**

California Grand Assembly 2010, Fresno, California  
March 26, 2010 thru March 30, 2010

TO: The Supreme Inspector for Nevada and Members of Nevada Grand Assembly, IORG

I, \_\_\_\_\_ **appoint, authorize and direct** Mrs. Joanie Jacka, the Supreme Inspector for Nevada Grand Assembly of the International Order of the Rainbow for Girls, or her designee as agent to authorize, in my behalf, emergency medical/surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent to the same extent as is executed personally by me.

In consideration for receiving the benefit of attending the above named event, we hereby release the Supreme Inspector or any designee appointed by her, the International Order of the Rainbow for Girls, the Assembly, the Masonic Fraternity, and any sponsoring body or affiliates thereof from any and all responsibility, liability or fault, which may arise as a result of any exercise of discretion with respect to the provision of travel and/or health care to our daughter which is authorized by this agreement. Furthermore, I agree to be fully and solely responsible for payment or reimbursement of any medical charges or expenses incurred and further agree to indemnify and hold harmless those released herein from any claim, demand or action which may be initiated against said parties for the recovery of such medical expenses, including any legal fees or expenses incurred in defending against such claims.

My personal insurance carrier is \_\_\_\_\_ Policy # \_\_\_\_\_

The name of my physician is \_\_\_\_\_

He/She may be reached at - Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Address Phone (\_\_\_\_) \_\_\_\_\_

If above cannot be reached, please call

Name \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Address Phone (\_\_\_\_) \_\_\_\_\_

I have the following allergies – \_\_\_\_\_

I have the following chronic/recurring illnesses – \_\_\_\_\_

I take the following medications – \_\_\_\_\_

I certify that all of the above information is correct

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***MUST BE SIGNED AND IN THE SUPREME INSPECTOR'S or her designee's POSSESSION AT ALL TIMES***