APPENDIX B

MEDICAL TREATMENT AUTHORISATION FORM

This form grants temporary authorisation to arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

THIS CONSENT FORM SHOULD BE TAKEN WITH THE CHILD TO THE HOSPITAL OR PHYSICIAN'S OFFICE WHEN THE CHILD IS TAKEN FOR TREATMENT.

Minor

Full Legal Name: _____

Home Address: _____

Date of Birth:_____ Gender: Female_____Male_____

Information for Medical Treatment:

Allergies to Medications or food:

_____

Special Medications, Blood Type or Pertinent Information

_____

Child's Physician _____ Phone _____

AUTHORISATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I hereby voluntarily grant my authorization and consent to the rendering of such care, including diagnostic procedures, any X-ray, anaesthetic, surgical and medical treatment and blood transfusions, deemed advisable by, and to be rendered under the general supervision of, physician, surgeon, dentist, hospital, or authorised members of other medical professional or institution duly licensed to practice in the country in which such treatment is to occur. It is understood that this authorisation is given in advance of any such medical treatment.

This authorisation is effective in the framework of the IAAF World Under 18 Championships taking place in Nairobi (Kenya) from 9th of July 2017 until 16th of July 2017. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

Signed on (Date) _____

_____ _____

Signature of Parent(s) or Legal Guardian(s)

_____ _____

Signature of Witness Witness Name