

NATIONAL SCIENCE FOUNDATION
4201 WILSON BOULEVARD
ARLINGTON, VIRGINIA 22230
OFFICE OF POLAR PROGRAMS

**AUTHORIZATION FOR TREATMENT OF FIELD-TEAM
MEMBER/PARTICIPANT UNDER THE AGE OF 18 YEARS**

I am the parent or guardian of _____, who is an under age participant in the United States Polar Programs. Should any medical/dental care be required during his or her deployment to Antarctica or to the Arctic, I hereby give my authorization and consent to the United States Polar Program's medical care provider(s) for any medical care, treatment or procedures that are deemed medically necessary while my son or daughter is deployed to either the Arctic or the Antarctic.

Name of Parent or Guardian

Signature and Date

Address _____

Telephone Numbers: Daytime: _____

Evening: _____