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: _____