

**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 legal 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 Legal Guardian

\_\_\_\_\_  
Signature and Date

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers: Daytime: \_\_\_\_\_

Evening: \_\_\_\_\_