EMERGENCY TREATMENT AUTHORIZATION FORM

To whom it may concern:
As a parent and/or guardian of _____, a minor, I hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

PLEASE PRINT

Name of Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Daytime Phone #: ( ) _____ - _____

Evening Phone #: ( ) _____ - _____

Family Physician _____

Physician's Phone #: ( ) _____ - _____

Date during which release is granted: From _____ To _____

Indicate specific medical allergies, chronic illness, or medical conditions coaches and medical personnel should be aware of:

_____

_____

Other person to contact in case of emergency:
_____

Relationship to child: _____

Daytime Phone #: ( ) _____ - _____

Evening Phone #: ( ) _____ - _____

This release form is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature: _____ Notarized by:
_____

Date: _____