**DIOCESE OF TRENTON**

***MEDICAL TREATMENT AUTHORIZATION FORM***

Fall_____ Level: Varsity / Junior Varsity

Winter_____ Level: Varsity / Junior Varsity

Spring_____ Level: Varsity / Junior Varsity

As parent and/or guardian of_____in homeroom_____, a minor, I hereby authorize the treatment of 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. I further authorize that my child may be transported to a hospital or emergency clinic for treatment.

Name of Parent/Guardian_____

Address_____

City_____State_____ Zip_____

Daytime phone number (____)_____

Evening phone number (____)_____

Email_____

Cell phone number (____)_____

Date during which release is granted: From 9/2019 To 6/2020

Other person to contact in case of emergency_____

Relationship to the child_____

Daytime phone number (____)_____

Evening phone number (____)_____

Cell phone number (____)_____

*Complete the reverse side indicating medical information*

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

Signature_____Notarized by_____

Date_____

Date of Birth_____

Physical Expires_____

(Office)

*Please complete reverse side*

Family Doctor_____

Address_____

Telephone_____

My child has a current physical on file_____

Has your child had a serious injury in the last year?

Yes____ No____

If yes, explain_____

Has your child had a seizure, concussion, or been unconscious in the last year?

Yes___ No____

If yes, explain_____

Has your child had surgery or been hospitalized in the last year?

Yes____ No____

Is your child an asthmatic or have serious allergies?

Yes____ No____

If yes, indicate the allergies and required treatment_____

_____

_____

Is your child on medication?

Yes____ No____

If yes, indicate the medication_____

I attest that my child is physically fit to participate in this sport activity.

_____Date_____

Parent Signature