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## Medical Treatment Authorization Form

As 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.

Name of Parent/Guardian \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

Home Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Other person to contact in case of emergency: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Cell Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

Home Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

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 \_\_\_\_\_ Date \_\_\_\_\_

***This form will be kept on file in coach's first aid kit at all games and practices for each athlete.***