MEDICAL HISTORY/MEDICATIONS and

EMERGENCY TREATMENT AUTHORIZATION FORM

To Whom It May Concern:

As a parent and/or guardian of, _____, 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

_____

Address _____

City _____ State _____Zip _____

Daytime Phone #: _____ Evening Phone #: _____

Family Physician _____

Phone #: _____ Cell Phone #: _____

Indicate specific medical allergies, chronic illnesses, or other 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 _____

Signature _____ Date _____

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.