

## AUTHORIZATION FORM FOR MEDICAL TREATMENT

Student: \_\_\_\_\_

Sport/Activity: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

**To whom it may concern:** In the event reasonable attempts to contact me at the locations listed below are unsuccessful, I, as a parent or legal guardian of the above student, do hereby authorize: (1) the treatment by a licensed medical physician of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence. *(please print)*

Name: \_\_\_\_\_ Relation to student: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies, Medicines, or Other Conditions: *(please list)*

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_