

# DIOCESE OF TRENTON

## MEDICAL TREATMENT AUTHORIZATION FORM

Sport: \_\_\_\_\_ 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 \_\_\_\_\_ To \_\_\_\_\_

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