



DIOCESE OF TRENTON

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. 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 # (____) _____

Evening phone # (____) _____

Family Physician _____ Phone _____

Date during which release is granted: From _____ To _____

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 _____

Daytime phone # (____) _____

Evening phone # (____) _____

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 _____