



## 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 \_\_\_\_\_ Notarized by \_\_\_\_\_

Date \_\_\_\_\_