

Medical Treatment Release

Name of Minor _____ Relationship to you _____

Specific medical allergies, chronic illnesses, or other conditions:

Medications that must be taken while participating in event:

Family Physician _____ Phone _____

Contact in case of emergency:

Name _____

Address _____

Phone _____

Medical Insurance Company _____

Group or Policy Number _____

As a parent or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above named minor in the event of a medical emergency, which, in the opinion of the attending physician, may endanger his 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. This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Legal Guardian Signature

Date