DIOCESE OF TRENTON

MEDICAL TREATMENT AUTHORIZATION FORM

Fall_____ Level: Varsity / Junior Varsity

Winter_____ Level: Varsity / Junior Varsity

Spring_____ 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: For the school year 20____ to 20____

Other person to contact in case of emergency_____

Relationship to the child_____

Daytime phone number (___)_____

Evening phone number (___)_____

Cell phone number (___)_____

Complete the reverse de 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