

EMERGENCY TREATMENT AUTHORIZATION FORM
ROCKAWAY TOWNSHIP

To Whom It May Concern:

As a 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.

Name of Parent or Guardian _____

Address _____

City: ROCKAWAY TOWNSHIP STATE: NEW JERSEY ZIP CODE: _____

E-MAIL ADDRESS _____

Home Phone () _____ Work Phone () _____

Pager () _____ Cell Phone () _____

Family Physician _____ Phone () _____

Hospital Affiliation(s) _____

Indicate specific medical allergies, chronic illness, or other medical conditions coaches and medical personnel should be aware of: (allergies, bee stings, medications, etc.) _____

Emergency Contact _____ Relationship _____

Home Phone () _____ Work Phone () _____

Pager () _____ Cell 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.
***** PLEASE SIGN BEFORE NOTARY PUBLIC *****

SIGNATURE (PARENT/GUARDIAN) : _____

I CERTIFY that on _____ 200 _____ Personally came before me and acknowledged under oath, to my satisfaction, that he/she is that person.
(Print Name)

(Notary Signature)

(Notary print name and title below signature)