

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: _____ 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 _____ 20____ (Print Name)
personally came before me and acknowledged under oath, to my satisfaction, that he/she is that person.

(Notary print name and Title below signature)