VERNON GIRLS SOFTBALL
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EMERGENCY TREATMENT AUTHORIZATION FORM

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, case 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/Guardian _____

Address _____

Town _____

Daytime Phone: _____ **Evening Phone: _____**

Cell Phone: _____

Family Physician: _____ **Phone: _____**

Insurance Coverage: _____ **Policy #: _____**

Dates during which release is granted: From _____ To _____

Indicate any specific medical allergies, chronic illnesses or other medical conditions coaches and medical personnel should be aware of: _____

_____

Other Emergency Contact: _____ **Relationship: _____**

Phone: _____ **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.

Signature _____ **Date _____**