

DIOCESE OF TRENTON

EMERGENCY INFORMATION FORM

Athlete's Name _____ **Sport** _____

Phone _____ **Email** _____ **Grade** _____

MANDATORY

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. 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 (____) _____ **Cell** (____) _____

Evening Phone (____) _____

Family Physician _____ **Phone** (____) _____

Date during which release is granted: From _____ **to** _____

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

Other person to contact in case of emergency: _____

Daytime Phone (____) _____ **Evening Phone** (____) _____

Cell (____) _____ **Relationship to Child** _____

IMPORTANT

Is your child allergic to any drugs? _____ If so, what? _____

Does your child have any other allergies? (e.g., bee stings, dust, peanuts) _____

Does your child have ____ asthma ____ diabetes, or ____ epilepsy? (Check all that apply)

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 _____ **Notarized by** _____

Date _____