

ST. ANNE'S BASKETBALL MEDICAL TREATMENT AUTHORIZATION FORM

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.

Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Mother's name & cell# _____

Father's name & cell# _____

Family Physician: _____ Ph # _____

Release granted during the 2023-2024 season

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: _____

Relationship to child: _____

Ph #: _____ Cell # _____

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: _____

COACHES WILL KEEP THIS FORM WITH THEM THROUGHOUT THE SEASON.