MEDICAL RELEASE - TREATMENT AUTHORIZATION FORM – TO BE NOTARIZED

Applicant's Name _____ Date of Birth _____

Parent/guardian first and last name (if participant is a minor) _____

Home address _____

Phone numbers: Home (____)_____Cell (____)_____ Work (____)_____

Alternate numbers: Name _____ Numbers _____ _____

Medical information: (i.e., allergies, medical and/or handicapping conditions & ongoing medication); please explain:_____

_____

Please list any medications you do not want to have if you come into a clinic.

_____

Physician's Name: _____Phone number ( ) _____

Insurance Company _____ Policy #_____ Phone (_____)_____

I am granting permission for me and/or my child to attend all Sport X Change functions. If I or my child should become ill or injured at an Sport X Change function, I or my child will expect to receive the proper care and that Sport X Change will (a) contact me immediately or (b) contact the person(s) I have designated if I cannot be reached.

Should Sport X Change personnel be unable to reach me and/or the person(s) designated, they are authorized to contact my or my child's physician and/or arrange for immediate emergency treatment.

The physician or medical facility is authorized to administer emergency medical treatment necessary to ensure the health and safety of me or my child. I agree to be financially responsible for emergency medical payments due to services rendered to me or my child in case of illness or injury, and I or my child will not hold Sport X Change liable for any accidents/injuries that may occur on Sport X Change foreign or domestic activities.

In case of minor injury, I authorize Sport X Change to provide first aid.
Signature of Participant (or Parent/Guardian if a minor):_____ Date: _____

I hereby certify that on this day the above participant personally appeared before me, and being personally known and/or identified, acknowledged before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

Witness my hand and seal at _____ County of _____

State of _____this _____ day of _____, 20_____.

Notary Public, State of _____ Signature _____

My commission expires _____ Name (please print) _____

_____