Medical History/Treatment-Authorization Form*

As a parent and/or a lawful guardian of ____, a minor, I hereby authorize
(Full name of youth sport athlete)
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. Medical providers are authorized to disclose on a "need to know" basis protected health information to the adult coach in charge, coaching staff and/or youth sport administrators of the program and/or any physician or health-care provider, such as but not limited to EMTs, who are involved in providing medical care to the individual minor named above for the purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardians and/or the determination of the youth athlete's ability to continue in the program's activities. This authority is granted only after a reasonable effort has been made to reach me.

Name ____
(Parent/Guardian with legal custody to be contacted in case of illness or injury)

Address ____

City ____ State _______________ Zip _________

Primary Phone # (________) ________-____________; e-mail _____________________________________

Secondary Phone # (________) ________-____________

Family Physician: ____ Phone # (_____) _______-____________

Dates during which this release is granted: From _________________________ to ____________________

Indicate medications currently being taken, specific allergies, chronic illnesses, or other medical conditions that coaches and medical personnel should be aware of:

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____
(If additional space is needed, please indicate that information on a separate sheet of paper and attach.)

Other person to contact in case of emergency: ____

Relationship to Child: ____

Primary Phone # (______) ________-____________; e-mail ____________________________________

Secondary Phone # (______) ________-____________

This release form is completed and signed by my own free will for the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature: ____________________________________ Date: ________________________________

Signature: ____________________________________ Date: ________________________________
(Second signature if required; for example, the state of California)

Notarized below

Notary Information will differ according to the state in which you reside

*This form is provided as a sample only. Usage of such a form should first be reviewed by the administrators of your youth sport program and their legal advisors.