

2006 MEDICAL TREATMENT RELEASE FORM

To whom it may concern:

As the parent(s) of _____, I do hereby authorize _____ or other senior members of WCA Club Name to seek treatment by a qualified and licensed Medical Doctor in an emergency, which in the opinion of the attending physician may endanger his/her 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.

Name of Parent(s) _____

Name of Minor _____ Relationship to you _____

Reason for which release is intended. _____

Address of Minor: _____ City: _____ Zip: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____ Zip: _____

List allergies, medications, contacts, or pertinent comments:

Health Insurance Data

Company _____ Policy Number _____

Group Number _____

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

Signed: _____ Date: _____

THIS FORM MUST BE NOTARIZED

Date

State of: _____ Subscribed and sworn to before me

County of: _____ this _____ day of _____ 20_____

_____ Notary Public

(MEDICAL PROVIDERS MAY NOT ACCEPT THIS IF NOT NOTARIZED)