Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be in the possession of the event leader or designated adult.

Minor

Full Legal Name: _____

Home Address: _____

Date of Birth: _____ Gender: Female _____ Male _____

Mother's Name: _____ Home or Cell Number: _____

Father's Name: _____ Home or Cell Number: _____

Emergency Contact: (if parent is not available) _____ Phone: _____

Parent e-mail address(es): _____

Information for Medical Treatment

Physician's Name and Location of Practice: _____

Physician's Phone Number: _____

Medical Insurer/Health Plan: _____ Policy Number: _____

Allergies to Medications: _____

Medications*****: _____

Please note all conditions for which the child is currently receiving treatment: _____

_____

Note any other significant medical information or allergies: _____

_____

***Prescription medication MUST be in pharmacy labeled containers.**

* **Provide a copy of the front & back of your insurance card**

-OVER-

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) AND RELEASE OF LIABILITY

I do hereby state that I have legal custody of the aforementioned minor. I grant my authorization and consent for Warren Wrestling Academy's authorized adult (hereafter "Designated Adult") to administer general first aid for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and to treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment but is given to provide authority and power on the part of the Designated Adult in the exercise of his/her best judgment upon the advice of any such medical or emergency personnel.

I also understand and agree that my child's participation in athletic and other activities involves the risk of injury and even death from various causes, including but not limited to accidents, fall, strenuous physical activity, dehydration, collision, weather, equipment defects, and negligence. On behalf of my child, I assume these risks. I hereby release, discharge, and hold harmless and indemnify, and covenant not to sue, Warren Wrestling Academy and/or its representative including staff, employees and volunteers.

Dates: Wednesday, June 23rd - Monday, June 28th

Parent/Legal Guardian Signature: _____

Printed Name: _____

Date Signed: _____

This authorization and release must be completed before participant can participate in any activities.
Treatment for injuries will be based on information provided herein.