

FOREST HILLS YOUTH FOOTBALL

2008 Medical Release

Child's Name: _____ Birthdate: _____

Player or Cheerleader? _____ Team Name: _____

Purpose: To allow parents to authorize emergency treatment for their child should they become ill or injured while under Forest Hills Youth Football authority, when parents cannot be reached.

COMPLETE EITHER PART I OR PART II BELOW !!!!

PART I TO GRANT CONSENT

If my child should become ill or injured, please contact:

Mother: _____ Phone: _____
 Father: _____ Phone: _____
 Guardian: _____ Phone: _____
 Other: _____ Relationship: _____ Phone: _____

If reasonable attempts to contact those listed above are unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by:

Preferred Physician: Dr. _____ **Phone:** _____

Preferred Dentist: Dr. _____ **Phone:** _____

In the event that the designated preferred practitioner is not available, I hereby give consent for treatment by another licensed physician or dentist. I also give consent for the transfer of my child to the following hospital or any hospital that is reasonably accessible.

Preferred Hospital: _____ **Phone:** _____

This authorization does not cover major surgery, unless written concurrence by two licensed physicians is obtained before the surgery is performed.

Facts concerning my child's medical history including allergies, medications being taken, and any physical impairments to which a physician or dentist should be alerted:

Parent/Guardian's Signature

Address

Date

PART II REFUSAL TO CONSENT

I DO NOT give my consent for emergency medical or dental treatment of my child. In the event of illness or injury requiring emergency treatment, I wish Forest Hills Youth Football to take no action or to: _____

Please contact:

Mother: _____ Phone: _____
 Father: _____ Phone: _____
 Guardian: _____ Phone: _____
 Other: _____ Relationship: _____ Phone: _____

Parent/Guardian's Signature

Address

Date