CLRD 2023 EMERGENCY MEDICAL RELEASE FORM

Participant's Name: _____
Address: _____

Purpose: To enable parents or guardians to authorize the provision of emergency medical treatment for minors who become ill or injured while under the authority of the Campbell Little Red Devils when parents or guardians cannot be reached.

Residential Parent or Guardian:
Mother's Name: _____ Father's Name: _____
Phone: _____ Phone: _____

Part I. To Grant Consent
I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Specialist: _____ Phone: _____
Hospital: _____ Phone: _____

If reasonable attempts to contact me have been unsuccessful, I hereby give consent for:

- The administration of any treatment deemed necessary by the above-mentioned medical care providers, or, in the event the designated preferred physician is not available, by another licensed physician.
- The transfer of a child to any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of two other licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications, and any physical impairment to which physicians or Campbell Little Red Devil's personnel should be alerted:
_____
_____
_____

Signature of Parent/Guardian: _____ Date: _____

Part II. Refusal of Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Columbiana Little Clipper Football authorities to take the following action:

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____