

WARREN TOWNSHIP RECREATION COMMISSION

46 Mountain Blvd

Warren, NJ 07059

Medical Treatment Authorization Form

(All information **MUST** be provided)

I, _____ (parent or guardian) hereby authorize the treatment of my child _____
_____ by a qualified and licensed medical doctor in the event of a medical
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 the emergency contact.

Childs Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Daytime Phone #: () _____ - _____

Evening Phone #: () _____ - _____

Family Physician: _____

Physician's Phone #: () _____ - _____

Dates during which release is granted: From: _____ To: _____

I certify that my child's immunizations are up to date. If your child does not get immunizations please add a
letter stating that you are exempt from getting immunizations.

Indicate specific medical allergies, chronic illnesses, other medical conditions and prescription
medications that medical personnel should be aware of. **This information will be kept completely
confidential.** (use back of form is necessary)

Emergency contact person: _____

Relationship to participant: _____

Emergency Contact Daytime Phone #: () _____ - _____

Emergency Contact Evening Phone #: () _____ - _____

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

Signature _____ Date: _____