

Medical Release Authorization Form

To Whom It May Concern:

I, _____ (Parent/Legal Guardian) authorize the representative of the (Lake Norman Lightning Organization) bearing this document to act on my behalf in case my child _____ requires emergency medical or surgical care, provided said representative makes a diligent effort to first contact me and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize said representative to take such action on my behalf as his/her judgment dictates.

Signature of Parent or Legal Guardian

Before me the undersigned authority on this day personally appeared _____, known to be the person whose name is subscribed to the foregoing instrument, and acknowledges to me that he/she executed the same for the purposes and considerations therein expressed and in the capacity therein stated.

Given under my hand and seal of office this _____ day of _____.

Notary Signature _____

Printed Name _____

Notary Public in and for _____ County, State

Family Physician _____ Phone _____

Insurance Company _____ Policy # _____

Hospital Preference _____

Allergies and or special medical conditions _____

Parent/Guardian Contact Information:

Father's Cell _____ Mother's Cell _____

Local Emergency Contacts

Name _____ Contact # _____

Name _____ Contact # _____