TEAMGOLDUSA MEDICAL TREATMENT AUTHORIZATION & RELEASE

TEAMGOLDUSA MEDICAL TREATMENT AUTHORIZATION & RELEASE This form authorizes medical treatment for your child if you cannot be reached in an emergency during practices, meets, or team travel.

Athlete Information Athlete Name: _____ Date of Birth: _____ Address: _____ City/State/ZIP: _____

Parent/Guardian Information Parent/Guardian 1: _____ Phone: _____ Parent/Guardian 2: _____ Phone: _____ Primary Email: _____

Emergency Contacts (if parents/guardians cannot be reached) Name: _____ Relationship: _____ Phone: _____ Name: _____ Relationship: _____ Phone: _____

Medical Information Physician Name: _____ Phone: _____ Preferred Hospital/Clinic: _____

Allergies (medications, foods, insects, etc.): _____ Current Medications: _____ Relevant medical conditions (asthma, diabetes, seizures, etc.): _____

Health Insurance Carrier: _____ Policy/Group Number: _____

Authorization for Treatment In the event that my child becomes ill or injured while participating in a TEAMGOLDUSA activity and I cannot be reached, I hereby authorize: • Coaches, chaperones, or designated adult representatives to seek emergency medical treatment for my child. • Qualified medical professionals to provide such treatment, including examinations, tests, anesthesia, surgery, or other necessary care, as judged by the attending medical provider.

I understand that reasonable efforts will be made to contact me before treatment is provided when possible. I accept financial responsibility for any medical care and transportation provided to my child.

Release I hereby release TEAMGOLDUSA, its coaches, officers, volunteers, and representatives from liability for decisions made in good faith regarding the medical care of my child in emergency situations.

Parent/Guardian Acknowledgment Parent/Guardian Name (print): _____ Signature: _____ Date: _____ Athlete Name: _____