



# Medical Release Treatment Form

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

As the parent/guardian of the above name minor, know that I may not be available to authorize medical, dental, surgical, and hospitalization of said minor child. I wish to appoint Forza Sports Academy staff to act in my behalf in my absence and to give such authorization. This authorization is intended to Forza Sports Academy staff to give consent to not only authorization for emergency diagnostic procedures, medical dental, surgical care and hospitalization, but for any diagnostic, medical dental surgical care, x-ray treatment and hospitalization that the person so designated deems advisable, and which the physician, dentist, or hospital personnel in said person's judgment may deem advisable.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the Forza Sports Academy staff, the doctors and medical staff, in deciding what treatment is to be given, but this is no way intended to restrict of authorization or consent by Forza Sports Academy. I understand that this form is in effect from the date signed and that it is my responsibility to inform Forza Sports Academy of any changes to this form. It is my understanding that this form also serves to establish my consent and permission for the above minor to participate in Forza Sports Academy training instructions and programs.

It is intended that this document be presented to the physician, dentist appropriate hospital or medical representative at such time as the medical, dental, surgical care or hospitalization shall be authorized. It is intended that the authorization relive the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above name minor, from signing a consent or authorization to render such care. It is the intent that Forza Sports Academy staff shall act in making such decisions.

Date of last Tetanus Booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

Known allergies, including any allergies to medicine \_\_\_\_\_

Any other medical problems which should be noted \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

Person to notify if parent/guardian is unavailable: \_\_\_\_\_ Phone#: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Forza Campiones Technical Training is "Simply the Best!"***  
**DEVELOPMENT BEFORE RESULTS!**