

# JR. GOLF MEDICAL INFORMATION/RELEASE

By completing and returning this form, I do herewith give permission for my child to participate in all the activities of the Elks Jr. Golf Program.

JR. GOLFER NAME \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICAL HISTORY (ALLERGIES, CHRONIC ILLNESS, OTHER CONDITIONS): \_\_\_\_\_

HOME PHONE \_\_\_\_\_ PARENT WORK PHONE \_\_\_\_\_

ALTERNATIVE EMERGENCY CONTACT: \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

## MEDICAL RELEASE

As a parent/guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above –named minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undo discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

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

The dates covered by this release are June through August.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or legal guardian)

(Note if you have any specific instructions regarding your child; i.e., what you wish us to do in the case of bee sting or any other specific medical concern that you may have, please inform us in writing. In addition: if you child is allergic to any medications- please list accordingly.)