



THE LONG VALLEY RAIDERS

FOOTBALL ASSOCIATION

2024 Membership Application

EMERGENCY TREATMENT AUTHORIZATION FORM

**FORM TO BE COMPLETED AND RETURNED TO YOUR CHILD'S HEAD COACH
BY THE FIRST PRACTICE (IN AUGUST).**

DO NOT MAIL TO THE PO BOX

To Whom It May Concern:

As a parent and/or guardian of _____, a minor, I hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency, which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Daytime Phone #: () _____ - _____

Cell Phone #: () _____ - _____

Evening Phone #: () _____ - _____

Family Physician: _____ Phone #: () _____ - _____

Dates during which release is granted: From _____ To _____

Coaches and medical personnel should be aware of: _____

Other person to contact in case of emergency: _____

Relationship to child : _____

Daytime Phone #: () _____ - _____

Cell Phone #: () _____ - _____