# ROC (Rockwall Oratorical Club)

**Medical Release**

The form pre-authorizes medical treatment for your child(ren) in the event of an **emergency** if you are not available to authorize treatment. Please fill out this form completely and sign it in the space indicated and return it to ROC. This medical release applies only in the event that neither parent listed on this form can be reached prior to medical treatment.

Child's name ____________________________ Age ________ Gender: M F

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Home Address: ____________________________________________________

Home Phone: ______________________ Work Phone: ___________________

Primary Care Physician: __________________ Phone #___________________

Allergies/Special Health Considerations: ________________________________

__________________________________________________________________

Mother's cell #: ____________________Father's Cell #: ___________________

Mother's Name: ___________________Father's Name: ____________________

I hereby authorize the Board Members or teachers of ROC to obtain medical treatment for the child or children above if neither my spouse nor I can be reached before the treatment is to be administered.

Mother's signature: ____________________Father's Signature: ____________________