Medical Release Form

In case of emergency, I grant consent to:

Tiffany Roberts, and/or the staff or volunteers at Saco Valley Gymnastics Training Center, LLC to authorize medical care for my minor child/children:

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Our Family Doctor is: ____________________________________

The Hospital we use is: ____________________________________

Allergies: ____________________________________

Contact me immediately at: ____________________________________

Alternate contact name and number: ____________________________________

Parent/Guardian Name: ____________________________________

Address: ____________________________________

Town: _______________ State: ____ Zip: _______

Phone: ____________________________________

Date: ____________________________________

Signature: ____________________________________