MEDICAL RELEASE FORM

I hereby authorize the staff of the Opportunity Networks to **obtain emergency medical treatment for** __________________ in the event that neither the parent nor the guardian can be reached and that it is necessary for the names individual's immediate well being to obtain treatment.

______________________________ ______________________

Signature: Individual Date

______________________________ ______________________

Signature: Guardian Date

______________________________ ______________________

Signature: Witness Date

______________________________ ______________________

Signature: Co-Guardian (if applicable) Date

11 Caldwell Drive, Amherst, NH 03031 603 883-4402 fax 603 883-4468
116 A Perimeter Road, Nashua, NH 03063 603 889-0796 fax 603 546-0128