



**FAIRFIELD POLICE DEPARTMENT**

**INJURY RELEASE**

100 Reef Road  
Fairfield, CT 06824  
203-254-4800

OFFICER COORDINATING ACTIVITY

PARTICIPANT's NAME	DATE OF BIRTH	HOME ADDRESS	HOME PHONE #
PARENT's NAME (If participant is a minor)	DATE OF BIRTH	HOME ADDRESS	HOME PHONE #

ACTIVITY VOLUNTEER IS PARTICIPATING IN:

DATE(S) OF ACTIVITY

**MEDICAL AUTHORIZATION**

I authorize the representative of the Fairfield Police Department to act in my behalf for the purpose of obtaining emergency medical treatment for the volunteer

YES       NO      INITIALS \_\_\_\_\_

FAMILY PHYSICIAN	PHONE
INSURANCE COMPANY	POLICY #
KNOWN ALLERGIES:	MEDICATIONS
KNOWN MEDICAL CONDITIONS	MEDICAL RESTRICTIONS
OTHER INFORMATION	

I, the above named volunteer or parent of the volunteer in the Fairfield Police Department's Volunteer Program, assume all risks and hazards incidental to the conduct of the activity and transportation to and from the activity. I am aware that participation in any program can be a dangerous activity involving many risks of injury. I do further release, absolve, indemnify, and waive any claims against the Fairfield Police department, Town of Fairfield, and any supervisors appointed by them.

I further state that I have read the foregoing Medical Authorization and know and understand the contents thereof, and freely sign the same

\_\_\_\_\_  
SIGNATURE (PARTICIPANT, PARENT, LEGAL GUARDIAN)

\_\_\_\_\_  
DATE

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC / POLICE OFFICER