

AUTHORIZATION FOR TREATMENT

Swimmer's Name _____ M F (circle one)

Date of birth ___/___/___

Name of Parent(s)/Guardian _____

Address _____ City/State/Zip _____

Phone (home) _____ (cell) _____ (cell) _____

Emergency Contact _____ Relationship _____

Phone (home) _____ (cell) _____

Allergies _____ Date of last tetanus shot _____

Other medical problems _____

Current medications _____

Physician/Pediatrician _____ Phone _____

Dentist _____ Phone _____

Medical Ins. Carrier _____ ID# _____ Group# _____

Policy Holder's Name _____ Policy Holder's DOB ___/___/___

Dental Ins. Carrier _____ ID# _____ Group# _____

Policy Holder's Name _____ Policy Holder's DOB ___/___/___

As the parent/legal guardian of the swimmer/diver listed above, I request that in my absence, this swimmer/diver be admitted to any hospital or medical facility for diagnosis and treatment. In the event that I cannot be reached, I hereby give permission to the physician, hospital staff, or dentist, to perform any procedures or treatments that are necessary for the medical emergency.

Signature of Parent/Guardian

Date