EMERGENCY MEDICAL AUTHORIZATION

MERCY HEALTHPLEX SWIM TEAM

****PLEASE COMPLETE ONE FORM FOR EACH SWIMMER****

SECTION A

SWIMMER'S NAME ____

DATE OF BIRTH ________________ SEX ___________

STREET ADDRESS ____

CITY _______________________ STATE ____________ ZIP ________

MOTHER'S NAME ____________________ PHONE NUMBER _____________

FATHER'S NAME _____________________ PHONE NUMBER _____________

PLACE OF BIRTH _________________________________

SECTION B

THE PURPOSE OF THIS FORM IS FOR PARENTS AND/OR GUARDIANS TO AUTHORIZE EMERGENCY MEDICAL TREATMENT FOR A CHILD WHO BECOMES INJURED OR ILL WHILE PARTICIPATING AS A MEMBER OF THE MERCY HEALTHPLEX SWIM TEAM.

PREFERRED PHYSICIAN:

DR. ______________________ PHONE NUMBER ____________________

LOCATION OF DOCTOR ____

PREFERRED HOSPITAL ____

PREFERRED DENTIST:

DR. ______________________ PHONE NUMBER ____________________

LOCATION OF DOCTOR ____

NAME OF INSURANCE COMPANY ________________________________

CARRIER ______________________________

*THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER PHYSICIANS OR DENTISTS HAVE BEEN GIVEN

SECTION C

1. HAS THE SWIMMER ABOVE HAS BEEN HOSPITALIZED FOR A SURGERY, INJURY OR SERIOUS ILLNESS? ________________________________

2. IS THE ATHLETE UNDER THE CARE OF A PHYSICIAN? _______________

3. MEDICATIONS, IF ANY _______________________________________

4. DO YOU FEEL THAT THE ABOVE ATHLETE SHOULD BE RESTRICTED IN ACTIVITY WITH COMPETITIVE SPORTS? ________________________

5. ALLERGIES ____

6. ALLERGIES TO MEDICATIONS ________________________________

7. HAS THE ABOVE ATHLETE EVER LOST CONCIOUSNESS DURING PHYSICAL ACTIVITY? _______________________________________

THE ABOVE IS TRUE AND ACCURATE AS STATED. ANY CHANGES IN THE INFORMATION WILL BE PROVIDED IMMEDIATELY TO THE COACH.

SIGNATURE OF THE PARENT OR GUARDIAN

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DATE ______________