

EMERGENCY MEDICAL AUTHORIZATION

MERCY HEALTHPLEX SWIM TEAM

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 _____

ID NUMBER _____

*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

DATE _____