



A USA Swimming Team
Emergency Medical Information/Treatment Form

Swimmer's Name: _____

Date of Birth: ___/___/___ Age: _____

Home Address: _____ Home Phone: _____

_____ Other Phone: _____

_____ Email: _____

List Any Allergies: _____

List Any Medical Conditions: _____

Parent's Names:

(1) _____ Home Phone: _____ Work: _____

Mobile: _____ Pager: _____

(2) _____ Home Phone: _____ Work: _____

Mobile: _____ Pager: _____

Emergency Contact Names:

(1) _____ Home Phone: _____ Work: _____

Mobile: _____ Pager: _____

(2) _____ Home Phone: _____ Work: _____

Mobile: _____ Pager: _____

Permission to Participate

I/We, the undersigned, certify that I/we am/are the parent(s) or guardian(s) of the above named child, that he/she is in good physical condition and I/we give my/our permission for him/her to participate in the AquaSol Sacramento Swim Team for the year 2007. I/we agree to assume full responsibility for any injuries incurred by him/her in connection with such participation.

Signature of Parent/Guardian

Dated: ___/___/___



A USA Swimming Team
Permission To Give Emergency Medical Treatment

I/We further authorize you to call the family physician listed below in case of emergency and request that I/we be contacted. If I/we are unable to be reached, I/we hereby authorize the physician or hospital to which my/our child is taken to perform all medical services or to have such medical services performed which in the opinion of the physician or hospital are reasonably necessary to the care of my/our child.

I/We agree further to authorize the leader of a team trip, an adult person into whose care the above-named child has been entrusted, to consent to any X-ray examination and the medical or surgical diagnosis or treatment and hospital care to be rendered to said child under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said swimmer by a dentist licensed under the provisions of the Dental Practice Act.

A photocopy of this form is as valid as the original.

This Authorization shall remain in effect until revoked in writing.

I/We agree further to assume responsibility for payment for the above-listed medical services provided to my/our child. My/Our medical insurance information is as follows:

Swimmers Name: _____

Physician Name: _____ Phone: _____

Insurance Company: _____ Phone: _____

Address: _____

Group Number: _____ Individual Number: _____

Secondary Insurance: _____ Phone: _____

Address: _____

Group Number: _____ Individual Number: _____

Dated: ____/____/____ _____

Signature of Parent/Guardian