NEW BREMEN BARRACUDA'S SWIM & DIVE TEAM
EMERGENCY MEDICAL AUTHORIZATION

PARTICIPANT'S NAME_____ M or F
ADDRESS_____CITY_____STATE/ZIP_____
TELEPHONE_____ AGE_____DATE OF BIRTH_____
The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured at practices or meets, when parents and guardians cannot be reached.
MOTHER'S NAME_____WORK PHONE_____
FATHER'S NAME_____ WORK PHONE_____
ALTERNATE EMERGENCT CONTACT_____ PHONE_____
FAMILY DOCTOR_____ PHONE_____
PREFERRED
HOSPITAL_____
IS YOUR CHILD ON ANY TYPE OF MEDICATION?_____YES _____NO
IF YES, WHAT?_____
DOES YOUR CHILD HAVE A MEDICAL ALLERGY?_____YES _____NO
IF YES, WHAT?_____
ANY OTHER INFORMATION WE SHIOULD KNOW?_____

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempt to contact both parents and the alternate emergency contact at the above phone numbers have been unsuccessful, I hereby give my consent for medial treatment to be provided by the above practitioners. Or in the event the designated preferred practitioner is not available, by another licensed practitioner and to transport the child to the preferred hospital.

_____DATE _____
signature of parent or guardian

_____
address

DO NOT COMPLETE PART II YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish no action to be taken or to_____

_____

_____DATE _____
signature of parent or guardian

_____
address

A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD