

**NEW BREMEN BARRACUDAS SWIM & DIVE TEAM
EMERGENCY MEDICAL AUTHORIZATION**

PARTICIPANT'S NAME _____ **M or F** _____
ADDRESS _____ **CITY** _____ **STATE** _____
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 EMERGENCY 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 SHOULD KNOW? _____

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact both parents and the alternate emergency contact at the above phone numbers have been unsuccessful, I hereby give my consent for medical 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.

Parent Signature _____ Date: _____

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

Parent Signature _____ Date: _____

A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD