

**Clifton Meadows Swimming & Diving Team
Emergency Medical Authorization 2008**

**Please Check: *swimming team* ___
diving team ___**

Child's Last Name First Name

Phone

Address

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating in any swimming and/or diving event.

A. Residential Parent or Guardian

Mother's Name

Mother's day & evening phone #'s

Father's Name

Father's day & evening phone #'s

Other Name

Other Phone

B. Name of Relative, Childcare Provider, or Emergency Contact

Name

Relationship

Address

Phone

C. To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name

Phone

Dentist's Name

Phone

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another physician or dentist; and, (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medication being taken, and any physical impairments to which a physician should be alerted: _____

Date

Signature of Parent/Guardian