



HEALTH ALERT

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Perry Aquatic Club authority, when parents or guardians cannot be reached. This information may be shared with the coaching staff to best meet your child's needs.

Swimmer Name: _____ Phone#: _____
 Address: _____ School District: _____
 _____ School Attending: _____
 Birth Date: _____ Sex: M F Grade: _____

Residential Parent or Guardian Information:

Mother: _____ Day Phone#: _____ Cell Phone#: _____
 Father: _____ Day Phone#: _____ Cell Phone#: _____
 Other Name: _____ Day Phone#: _____ Cell Phone#: _____
 Other Name: _____ Day Phone#: _____ Cell Phone#: _____

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

Doctor: _____ Phone#: _____
 Dentist: _____ Phone#: _____
 Medical Specialist: _____ Phone#: _____
 Hospital: _____ Phone#: _____

Below check any current health condition that may require attention during practice or a swim meet:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Concussion/head injury --- Year _____
<input type="checkbox"/> Foods	<input type="checkbox"/> Physical disability (be specific) _____
<input type="checkbox"/> Medicines	<input type="checkbox"/> Respiratory (be specific) _____
<input type="checkbox"/> Bee Stings <input type="checkbox"/> EpiPen	<input type="checkbox"/> Seizures
<input type="checkbox"/> Other	<input type="checkbox"/> Vision Problems (be specific) _____
<input type="checkbox"/> Asthma <input type="checkbox"/> Inhaler	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
<input type="checkbox"/> Cancer	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Behavior/emotion problems _____
<input type="checkbox"/> Hearing Problems <input type="checkbox"/> Hearing Aid(s)	<input type="checkbox"/> Other (be specific) _____
<input type="checkbox"/> Heart Problems (be specific) _____	
<input type="checkbox"/> Surgeries (include year) _____	

List all medications and dosages your child receives on a continual basis:

PLEASE COMPLETE PART I OR PART II---- NOT BOTH

Part I - TO GRANT CONSENT

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 the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

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

Date: _____ Parent or Guardian Signature: _____

Part II-REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Perry Aquatic Club authorities to take no action or to: _____

Date: _____ Parent or Guardian Signature: _____