

Arkansas Dolphins Swim Team Medical Information Sheet

Permission and Release

I hereby give my permission for _____ age _____ to participate/accompany Arkansas Dolphins to _____ in _____, on _____.

I further waive all claims for injury, accident, or liability of any kind for the above-mentioned swimmer, and in case of an accident or injury in any way resulting, directly or indirectly from participation in such program, hold harmless from any liability therefore the Arkansas Dolphins, ASI, USA Swimming, the meet hosts and facilities, its officers, coaches, chaperones, managers or any other person(s) in any way connected or associated with the program. I understand that the Coaches, Chaperones, and Zone Coordinator are not responsible for dispensing medication or providing medical treatment for athletes.

Medical Information

List any medication and dosage the swimmer is currently taking:

Permission to take: Tylenol _____ Motrin _____ Advil _____ Tums _____ Pepto-Bismol _____

Pre-existing medical conditions (asthma, epilepsy, etc) _____

Allergies (including medicines): _____

Other pertinent information: _____

Physician's name _____ Phone: _____

Dentist name _____ Phone: _____

In the event of an emergency, I may be contacted at the telephone numbers and addresses listed below:

Parent/Guardian: _____ Phones: _____

Addresses: _____

Emails: _____

Medical Waiver and Authorization

Effective immediately and continuously for the period set forth in the first paragraph above, I authorize all healthcare providers or other covered entities to disclose to one or more of the Arkansas Dolphins coaches, coordinators and chaperones (a Dolphin's Representative), upon any such person's request, any information, oral or written, regarding the physical or mental health of the swimmer, including, but not limited to, medical and hospital records, including what is otherwise private, privileged, protected or personal health information, including but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024), the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be further disclosed as no longer subject to the rules of 45 CFR § 164.

Furthermore, in case of a medical situation, I hereby authorize a Dolphins Representative to act for me according to such persons best judgment and ability. Specifically, in the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accident injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Insurance Company _____ Policy Number _____

Phone Number: _____

Dental Insurance company _____ Policy Number _____

Phone Number: _____

NOTARIZATION

STATE OF ARKANSAS
COUNTY OF _____

On this ____ day of _____ 2015, the said _____, known to me (or satisfactorily proven) to be the person(s) named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that he/she/they freely and voluntarily executed the same for the purposes stated therein.

Notary Public

My Commission Expires:

(S E A L)