Michigan Lakeshore Aquatic's: EMERGENCY MEDICAL RELEASE FOR SWIMMER

If the swimmer identified below becomes ill, is injured or otherwise needs emergency medical attention, I authorize Michigan Lakeshore Aquatics (MLA), through (**Name of Activity Director or Designee**) or **his/her** designee/chaperone, to obtain medical assistance. I authorize the activity director or designee named above to act for me according to **her/his** best judgment and ability. This authorization covers all times that the swimmer is under the supervision of MLA for **(Name of Activity)**.

SWIMMER INFORMATION:

NAME: ____ Date of Birth: ________________ Age: _______

PLEASE PRINT

ADDRESS:____

Street City ZIP

List any medications and dosage that the swimmer will be taking during the trip.
Does the chaperone/coach need to supervise the administration of this medication?

Name of Medication	Dose	Time of Administration

List all known allergies: ____

Pre-existing health conditions: ____

PARENT/GUARDIAN INFORMATION:

	MOTHER/GUARDIAN	FATHER/GUARDIAN
NAME		
ADDRESS		
HOME PHONE		
EMPLOYER		
WORK PHONE		
CELL PHONE		
INSURANCE COMPANY		
POLICY NUMBER		

	NAME	ADDRESS	PHONE
CHILD'S DOCTOR			
CHILD'S DENTIST			

Any other pertinent information that MLA should know about the swimmer?

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TREATMENT AUTHORIZATION (Please attach copy of insurance card):

If my child needs treatment, I request that you try to contact us to authorize treatment. In my absence, I have given the following person(s) my consent to authorize treatment for my child:

____

Name/Relationship Address Phone

<u>PARENTAL CONSENT FOR TREATMENT OF A MINOR</u>

If a situation occurs in which the minor listed above needs immediate medical attention, and I or any authorized individual(s) are unavailable to give consent, this signed statement will serve as an authorization for the nearest hospital and its Medical Staff to proceed with whatever medical care is in the child's best interest until such time as I or an authorized individual can be reached. I understand that the hospital will make every effort to contact me before initiating treatment.

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Signature of Parent/Legal Guardian Date