Miami County Marlins Swim Team
Emergency Medical Authorization Form

Swimmers Name: _____Birthdate: _____

Home address: _____

_____

Home Phone:_____ Mother's Cell Phone: _____

Mother's Work Phone:_____ Father's Cell Phone: _____

Father's Work Phone:_____

IN CASE OF AN EMERGENCY, IF UNABLE TO CONTACT A PARENT/GUARDIAN, CALL:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under the swim team's authority, when parents cannot be reached.

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT (PLEASE SIGN ON NEXT PAGE FOR PART I)

In the event reasonable attempts to contact me at _____ (phone #) or _____ (other parent) at _____ (phone #) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone no.) or Dr. _____ (preferred Dentist) at _____ (phone no.) or, in the event the designated preferred practioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any other hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted are as follows:

_____
_____
_____
_____
_____

DATE: _____
SIGNATURE OF PARENT OR GUARDIAN: _____

PART II – REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the swim team authorities to take no action or to do the following:

_____
_____
_____

DATE: _____
SIGNATURE OF PARENT OR GUARDIAN: _____