TEAM TRAVEL

Medical & Food

Athlete Name ____

Meet Name ______________________________ Travel Dates ______________

EMERGENCY CONTACT _________________________ **Phone** _______________

AUTHORIZATION TO CONSENT TO EMERGENCY TREATMENT OF MINOR

I/WE, THE UNDERSIGNED PARENT(S) OF ____________________, a minor, do hereby authorize the assigned team chaperone(s), registered Non-Athlete USA Swimming Member, as agent for the undersigned to consent to any emergency, x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable, and is to be rendered under the general supervision of any licensed physician and surgeon when parent or guardian is unavailable and cannot be immediately contacted. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the agent to give specific consent to any and all such emergency diagnosis, treatment or hospital care which the aforementioned phsycian in the exercise of their best judgment may deem advisable.

Parent/ Legal Guardian Signature ____________________ **Date** ________________

For Patient Protection

1. Allergies and sensitivities: Is there a history of skin or other reaction or sickness following injection or oral administration of:
   - Penicillin YES NO
   - Morphine, codeine, demerol or other narcotics YES NO
   - Novocain or other anesthetics YES NO
   - Aspirin, emperin or other pain remedies YES NO
   - Sulfa drugs YES NO
   - Tetanus, antioxin or other serums YES NO
   - Adhesive tape YES NO
   - Iodine or methiolate YES NO
   - Any other drugs (describe) ____________________
   - Any foods such as milk, eggs or chocolate (describe) ____________________
2. List of known allergies or allergic reactions
   - ____________________
   - ____________________
3. Date of last tetanus booster? ____________________
4. Drugs taken within past 6 months
   - Cortizone YES NO
   - ACTH YES NO
   - Anticoagulants YES NO
   - Tranquilizers YES NO
   - Hyposensitives (high blood pressure) YES NO
5. Has the swimmer received treatment for
   - Asthma YES NO
   - Rheumatism YES NO
   - Rheumatic Fever YES NO
6. Other medical conditions or treatments
   - LIST ____________________
7. Medical Insurance ____________________
   - Policy Number ____________________
   - Patient's ID Number ____________________
   - Phone # to obtain authorization for emergency treatment (usually 1-800) ____________________
8. Do you give the Coaches and Chaperones the authority to administer over-the-counter drugs (aspirin, cough medicine) to your swimmer? YES NO PLEASE CALL

Parent / Legal Guardian Signature ____________________ **Date** ____________________

Food Planning

Please list all food-related requirements and strong preferences for the trip (include allergies, vegetarian, vegan, etc.):

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

Parent / Legal Guardian Signature ______________________ **Date** ____________________