Carter Center Aquatics Marlins

Medical Information / Consent for Emergency Medical Treatment

(1 form required per Swimmer)

Swimmer's Name_____ Date of birth_____

Address_____ City/Zip Code_____

Parents' Name_____ Phone_____

Address_____ City/Zip Code_____

Business Name_____ Phone_____

- Are you allergic to any medication? No Yes (list) _____
- Do you take any prescribed medications? No Yes (list) _____
- Have you ever had an epileptic seizure? No Yes (date)_____
- Do you have asthma? No Yes (inhaler)_____
- Have you been admitted to the hospital in the last three years? No Yes (reason for hospitalization)

_____

- Do you wear contacts or prescription goggles while swimming? No Yes
- Have you ever had a shoulder injury? No Yes (what type)_____
- Have you ever had shoulder surgery? No Yes (date)_____
- Have you ever had knee problems? No Yes (what type)_____
- Have you broken or sprained/strained anything in the last three years? No Yes (describe)

_____

- Have you been diagnosed with diabetes? No Yes
- Have you been diagnosed with hypoglycemia? No Yes
- Have you been diagnosed with ADD? No Yes (medication)_____
- Do you have any other conditions that we should be aware of? No Yes (list)_____

_____

- Date of last tetanus and polio shots T_____ P _____

The above named swimmer has my/our permission and consent to travel with the CCA Marlins coach(es) and/or any official chaperones. We transfer parental responsibility of said swimmer to the CCA Marlins coach(es) and/or representative(s) for the duration of the meet(s) including travel to and from the meet(s).

I/We, the parent(s) or authorized guardian of _____, do hereby authorize the head coach or any employee of North Cross School/CCA Marlins to consent on my/our behalf to any examination and/or medical or surgical diagnosis or treatment, including emergency or hospital care deemed advisable and rendered by a licensed physician, certified emergency medical personnel or other agent of either. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care but is given to provide advanced authority of such agents to consent to all such diagnosis and treatment. I/We acknowledge that I/we will remain responsible for the cost of such treatment.

Parent(s) Signature_____ Date_____

Insurance carrier _____ Policy No. _____

Name of policy holder _____ Identification No. _____