Desert Wave Aquatics Club
Medical Information/Release Form

In the event of a medical emergency, we will make reasonable efforts to immediately contact responsible parties. Please provide the following information:

Date / /

Athlete's Name		Age	Gender	DOB
Address				
City, State Zip				
Father's Name		Father's Employer		
Home Phone	Cell Phone	Work Phone		
Mother's Name		Mother's Employer		
Home Phone	Cell Phone	Work Phone		
Doctor	Phone	Hospital		
Medical Insurance Company		Phone		
Policy Number	Group Number			

If any of the following conditions pertain to the athlete, please indicate by checking box and provide any pertinent additional information in space below.

❏Allergies ❏ Skin Problems ❏ Diabetes
❏Sensitivity to Medications ❏ Stomach Problems ❏ Arthritis
❏Kidney/Urinary Problems ❏ Heart Problems ❏ Current Medications
❏Ear Problems ❏ Eye Problems ❏ Asthma/Lung Problems

❏Recent Injuries:_____

❏Other:
_____

_____

_____

If, in the event that this athlete should need immediate medical treatment due to any injury or sickness, I do hereby request, authorize and consent to such treatment as deemed necessary. I also agree to indemnify and save Desert Wave Aquatics Club (DWAC) and any representative from any claim related to such treatment. Further, I will pay any amounts not covered by the insurance carrier and will not hold DWAC responsible for the balance of any related medical bill.

I/we understand that DWAC does not furnish additional insurance coverage (aside from the USA swimming insurance provided through membership of USAS) of any kind or nature for anyone for any reason, and I/we hereby release, agree to defend, and hold harmless DWAC and all of its affiliates, agents and associates from any liability whatsoever that may arise pertaining to me or my family, from any cause or reason of any nature. I/we understand the meaning of the liability release to its fullest extent, and agree to same without reservation or exceptions.

Parent Signature _____ Date _____