TRAINING GROUP(if known:_____

YMCA of WOOSTER SWIMMER REGISTRATION/MEDICAL FORM

Purpose: To enable parent and guardians to authorize the provision of the emergency treatment for children who become ill or injured while under the Wooster YMCA Swim Team authority, when parent(s) cannot be reached.

Swimmer's Name:_____ Date of Birth:_____

Address:_____ City:_____

Mother's Name:_____ Cell phone:_____

Father's Name:_____ Cell Phone:_____

Mother's email:_____ Father's email:_____

Insurance Company:_____ Insured Name:_____

Account #:_____ Group #:_____

GRANT CONSENT FOR MEDICAL TREATMENT:

I hereby give consent for the following medical care providers and local hospital to be called:

Physician Name:_____ Physician Phone:_____

Dentist Name:_____ Dentist Phone:_____

Local Hospital:_____

In the event reasonable attempts to contact me have not been successful, I hereby give my consent for

(1) the administration of any treatment deemed necessary by above named physicians, or, In the event the designated preferred doctor is not available, by another licensed physician or dentist; and

(2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover surgery unless the medical opinions of two licensed physicians or dentist, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning medical conditions, medications or physical impairment the physician should be alerted to:

Remarks:_____

Allergies:_____

Parent/Guardian Signature:_____ Date:_____