

Emergency Medical Information

(One Form Per Family)

Swimmer's Name	Birth Date	Allergies	Last Tetanus (if known)	Medical Problems

Mother: _____ Home Phone _____ Mobile _____ Work _____

Father: _____ Home Phone _____ Mobile _____ Work _____

Swimmers Home Address: _____

Other Emergency Contacts: _____ Phone(s): _____

_____ Phone(s): _____

Do you have insurance? Y N Insurance Company: _____ Telephone: _____

Name of the Insured: _____ Relationship to Swimmer(s): _____

Group Number: _____ Certificate No.: _____ SS No. of Insured: _____

Insured's Place of Employment: _____ Telephone: _____

Home Telephone: _____ Other Telephone: _____

Physician: _____ Telephone: _____

Dentist: _____ Telephone: _____

Authorization to Consent to Treatment of a Minor

NAME OF MINOR: _____ NAME OF MINOR: _____ NAME OF MINOR: _____

NAME OF MINOR: _____ NAME OF MINOR: _____ NAME OF MINOR: _____

I AUTHORIZE the Northwest Aquatic League (hereinafter referred to as "the NWAL") and/or the Jersey Village Swim Team (hereinafter jointly referred to as "the JVST/NWAL") authorized representative(s) (hereinafter referred to as "the Adult") to consent to medical treatment of such minor when I cannot be contacted to so consent, such medical treatment to include, without limitation, x-ray, examination, anesthetic, medical, dental, or surgical examination or treatment and general hospital care. NO prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment as needed be made under this Authorization.

I SPECIFICALLY CERTIFY AND AGREE THAT: Except as indicated at the end of this paragraph, 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 Adult to give specific consent to any and all such examinations, treatment or hospital care. EXCEPTION: This Authorization is in effect from April 1, 2008 through August 30, 2008 only.

The possession of the original of this Authorization by the Adult is evidence that he/she has care and control of such minor and that I cannot be contacted.

I will indemnify and hold harmless from any expenses or claims of any nature any entity which provides or causes to be provided examination, treatment or hospital care pursuant to this Authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, buy assignment of third party benefits or otherwise, full and complete payment of such examination treatment, or hospital care.

I am the person having the power to consent to medical treatment of such minor.

This Authorization shall remain effective for the period as noted above in 'EXCEPTION'; unless sooner revoked by the physical destruction of the original hereof, such destruction being the only method of actual notice of the revocation of the same.

All blanks of this Authorization were filled in before I signed this Authorization.

Signature: _____ Printed Name: _____ Date: _____