Wolverine Aquatics Club
Emergency Medical Information/Treatment Authorization Form

Swimmer Information:
Swimmer's Name: _____
DOB: _____ Age: _____
Home Address: _____
Home Phone: _____ Alt. Phone #1(_____): _____
Alt. Phone #2 (_____): _____ Additional Contact info.: _____
List any allergies: _____
List any medical conditions: _____
List any prescription and over-the-counter medications: _____
_____

Parent Information:
Parent #1 Name: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____ Email: _____
Parent #2 Name: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Information:
Name/Relation: _____ Primary Phone: _____
Alt. Phone #1 _____ Alt. Phone #2 _____
Name/Relation: _____ Primary Phone: _____
Alt. Phone #1 _____ Alt. Phone #2 _____

Permission to Participate:
I, the undersigned, certify that I am the parent/guardian of the above-named child and that he/she is in good physical condition and I give my permission for him/her to participate in Wolverine Aquatics Club. I agree to assume full responsibility for any injuries incurred by him/her in connection with such participation.

_____ _____
Signature of Parent/Guardian Date

Permission to Give Emergency Medical Treatment:
The undersigned hereby authorizes Chris Breitbart or such substitute as he may designate as agent for the undersigned to consent to any x-ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medical Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere. A photocopy of this form is as valid as the original. This Authorization shall remain in effect until revoked in writing. I agree to assume responsibility for payment of the above-listed medical services. My/our medical insurance information is as follows:

Physician's Name: _____
Address: _____
Doctor's Office Phone: _____Doctor's Emergency Phone: ____ _____
Medical Insurer/Health Plan: _____ Policy/Group #: _____
Parent/Guardian Signature:_____
Parent/Guardian Printed Name: _____ Date: _____