Wisconsin Swimming, Inc.
EMERGENCY MEDICAL RELEASE FOR SWIMMER

If the swimmer identified below becomes injured or otherwise needs emergency medical attention, I authorize Wisconsin Swimming, through **(Name of Activity Director or designee)** or **his/her** designee/chaperone, to obtain medical assistance. I authorize the activity director or designee name above to act for me according to **her/his** best judgment and ability. This authorization covers all times that the swimmer is under the supervision of Wisconsin Swimming, Inc. for **(Name of Activity.)**.

SWIMMER INFORMATION:

NAME: ___________________________________ Date of Birth: _____________ Age: ___________
PLEASE PRINT

ADDRESS: ____
Street City ZIP

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List any medications and dosage that the swimmer will be taking during the trip. Does the chaperone/coach need to supervise the administration of this medication? ____ yes ____ no

NAME OF MEDICATION	DOSE	TIME OF ADMINISTRATION

Pre-existing Health Conditions: ____

____

PARENT/GUARDIAN INFORMATION:

	Mother/Guardian	Father/Guardian
NAME		
ADDRESS		
HOME PHONE		
EMPLOYER		
WORK PHONE		
CELL PHONE		
INSURANCE COMPANY		
POLICY NUMBER		

	NAME	ADDRESS	PHONE
CHILD'S DOCTOR			
CHILD'S DENTIST			

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Any other pertinent information that Wisconsin Swimming, Inc. should know about the swimmer?

_____

_____

TREATMENT AUTHORIZATION (Please attach copy of insurance card):
If my child needs medical treatment, I request that you try to contact us to authorize treatment. In my absence, I have given the following person(s) my consent to authorize treatment for my child:

_____
Name/Relationship Address Phone

PARENTAL CONSENT FOR TREATMENT OF A MINOR

If a situation occurs in which the minor listed above needs immediate medical attention, and I or any authorized individual(s) are unavailable to give consent, this signed statement will serve as an authorization for the nearest hospital and its Medical Staff to proceed with whatever medical care is in the child's best interest until such time as can be reached. I understand that the hospital will make every effort to contact me before initiating treatment.

_____
Signature of Parent/Legal Guardian Date

September 1, 2011