



EMERGENCY RELEASE FORM

This form must be completed before each swimmer begins swimming with the Wyoming Waves Swim Team. The Information will be held in the swimmer's file for use only in the event of an emergency.

Swimmer's Name: _____ Date of Birth: _____

Father's Name: _____

Father's Home Phone: _____ Work Phone: _____ Cell: _____

Mother's Name: _____

Mother's Home Phone: _____ Work Phone: _____ Cell: _____

IN THE EVENT OF AN EMERGENCY NOTIFY:

NAME	RELATIONSHIP	PHONE

PHYSICIAN

Name: _____ Phone: _____ Address: _____

Insurance: _____ Group # _____

Health History (Please circle those that apply)

Hearing Impaired	Visually Impaired	Contact Lenses	Epilepsy
Diabetes	Asthma	Other (list: _____)	

Does swimmer take medication? NO YES If yes, please list type & frequency:

Does swimmer have allergies? NO YES If yes, please list:

Does swimmer have other medical conditions? NO YES If yes, please list:

MEDICAL AUTHORIZATION:

I, _____ (Parent/Guardian) in the event of an accident, injury or serious illness To the above swimmer, do voluntarily consent to and authorize the Wyoming Waves Swim Team to Secure medical aid at a center selected by Wyoming Waves Swim Team (which may include routine Diagnostic procedures, medical and/or surgical treatment including injection, anesthesia, or transportation To a medical facility.)

I understand that an effort will be made to contact myself or any of the individuals listed above before any Action is taken. I understand that my swimmer's membership in the United States Swimming provides some Insurance coverage and that I am responsible for medical costs in excess of this coverage. I understand that Wyoming Waves Swim Team does not guarantee the results of any medical treatment and will have any or all examinations/treatments done by authorized persons or facilities.

BY MY SIGNATURE, I AUTHORIZE AND GIVE MY PERMISSION FOR MEDICAL TREATMENT OF MY SWIMMER (S).

Signature of the Parent or Guardian: _____

Date: _____