

Emergency Medical Release Form

Please Print All Information, Except For Signatures

Swimmer Identification

Name: _____ Date of Birth: _____ Age: _____
 Address _____
 Street: _____ City: _____ Zip: _____

List any medications and dosages that the swimmer will be taking during the trip.

Does someone need to supervise the administration of the medication? Yes ___ No ___ N/A ___

List pre-existing medical conditions; e.g, Epilepsy, any **Allergies**, Asthma, this swimmer is subject to::

List any other medical information about this swimmer that the Head Coach or his staff should know

Medical Insurance Data

Company _____ Policy# _____
 Name of Policy Holder: _____

Swimmer's Primary Care Physician:

Name: _____ Phone# _____

Person to contact in an Emergency

Name _____ Relationship to Swimmer _____
 Telephone: Day (_____) _____ Evening (_____) _____
 Cellular Phone: (_____) _____ Other (_____) _____

If the swimmer identified above becomes injured or otherwise needs emergency medical attention, I authorize Coral Springs Swim Club through the CSSC Head Coach, Mr. Michael Lohberg, **or his designee** to obtain medical assistance. I authorize him or his designee to act for me, according to his or her best judgment and ability. This authorization covers all the time that the swimmer is under the supervision of CSSC personnel.

Parent or Guardian Name: _____

Please Print

Signature: _____ Date: _____