Medical Authorization and History

Print Name of Rower _____

Print Name of Parent or Legal Guardian

_____

Relationship to Rower

_____

I hereby authorize and consent to the administration of any and all medical, dental, and surgical examinations or operations and treatment or all other related care, including the administration of drugs, tests, anesthesia and/or blood transfusions to the above named minor person that may be ordered by a physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above named minor person to the hospital.

Parent or Legal Guardian Sign here_____
Date_____

I understand that Community Rowing Inc. and its officers, employees and volunteers assume no financial obligation or liability in the case of my child's accident or illness. If I, or anyone on my or my child's behalf makes a claim against Community Rowing Inc. or their officers, employees or volunteers arising from to my child's participation in Community Rowing Inc. programs, I agree to indemnify and hold them harmless from any litigation expenses, attorneys' fees, loss, liability, damage or costs they may incur due to the claim made against any of them, whether the claim is based on their negligence or otherwise. I sign this agreement on my child's behalf, my behalf and on behalf of my personal representatives, assigns, heirs and next-of-kin. I hereby give my permission for emergency treatment for my child and assume financial responsibility for such treatment.

Parent or Legal Guardian Sign here_____
Date_____

*** Please continue with medical history on the following page. ***

Rowers Name_____
Date_____
First person to contact in an emergency:
Name_____
Relationship to Rower_____
Phone (day)_____
Phone (eve)_____ Phone (cell)_____
Alternate person to contact in an emergency:
Name_____
Relationship to Rower_____
Phone (day)_____
Phone (eve)_____ Phone (cell)_____
Physician (include Name, Phone Number & Address)
_____
Health Insurance Co._____
Medical Policy #_____
Asthma Yes_____ No_____ Does your child carry an inhaler?_____
Usual cause of asthma occurrence_____
Allergies_____
Medications_____
Diabetes Yes_____ No_____ Frequency of dosage and type of Insulin_____
Medical Concerns_____

Revised 6/28/18