



EMERGENCY MEDICAL FORM  
2017-2018

PLEASE PRINT:

ONE FORM PER SWIMMER

Swimmer's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email Address: \_\_\_\_\_ Cell: \_\_\_\_\_

Cell phone carrier: (ex. Verizon) \_\_\_\_\_ (We will text cancellations if they are last-minute)

Father's Full Name \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Full Name \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please indicate any known restrictions or limitations on your child's activities, including any injuries or illnesses which might impact your child while participating in a competitive swimming program. (Use back of form for additional space)

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please describe any allergies or medical conditions: \_\_\_\_\_

Regular Medication: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Health Insurance Phone # \_\_\_\_\_

If neither parent can be contacted in the case of a serious injury or illness, I hereby authorize a representative of Pine Richland Aquatics, Inc. to secure emergency medical treatment from any recognized doctor or hospital for my child if such doctor determines that such treatment is necessary or advisable.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_