Authorization for Medical Treatment

In the event my son/daughter ___________________________ is injured or becomes ill during the period of September 1st 2007 to September 1st 2008, while participating in activities of the River City Rowing Club, I consent to whatever x-ray, examination, anesthetic, medical, dental or surgical diagnosis, treatment and/or hospital care from a licensed dentist, physician and/or surgeon when deemed necessary for his/her safety and welfare. I understand that the resulting expenses, including transportation, if necessary, will be my responsibility. A copy of this document has the same authority as the original.

- PLEASE PRINT ALL INFORMATION <u>COMPLETELY & CLEARLY</u> –

Medical Insurer & Policy number:____

Physician & phone number:____

Dentist & phone number: ____

Known allergies or conditions:____

____

Parent/Guardian Contact Information:

Name & relationship:____

Day phone:_____________________ Evening phone:______________________

Cell phone:_____________________

Emergency Contacts :

Name & relationship:____

Day phone:_____________________ Evening phone:______________________

Cell phone:_____________________

Name & relationship:____

Day phone:_____________________ Evening phone:______________________

Cell phone:_____________________

Signature____ Date_______________