Colonel Crawford Summer Swim Team
EMERGENCY MEDICAL AUTHORIZATION

Swimmer's Name	Mother's Name
Home Address	Mother's Work Place
Home Phone	Mother's Work Phone
School Attended	Father's Name
Swimmer's Birthday	Father's Work Place
Cell Phone (mom or dad) circle one	Father's Work Phone

Purpose - to enable parents to authorize emergency treatment for children who become ill or injured while under Colonel Crawford Summer Swim Team authority, when parents cannot be reached.

PART I OR II MUST BE COMPLETED

(Part I to grant consent)

In the event of reasonable attempts to contact me _____(Name) at _____(Phone Number) or _____(Other Name) at _____(Phone Number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr._____ (Preferred Physician) or Dr._____(Preferred Dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) their transfer of the child to _____(Preferred Hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____ _____
Parent's Signature Date

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
Part II refusal to consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Col. Crawford Swim Team take no action or to: _____
_____
_____
_____
_____

_____ _____
Parent's Signature Date