Medical Consent Authorization

Check with a physician before beginning the rowing program. Please attach a copy of your insurance information to this form.

Rower's Name: _____Date of Birth: _____

Address: _____ Phone: _____

Medical Provider Information:

Insurance Provider: _____ Policy#_____

Physician: _____ Physician's Phone: _____

Physician's Address: _____

In case of an Emergency, Contact:

_____

Name Phone Relationship

_____

Name Phone Relationship

Known Medical Problems and Medications: *This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.*

Existing Medical Problem	**Medication Taken**	**Dosage Taken**	**Dosage Frequency**
(Example: Asthma)	**(Example: Combivent)**	**(Example: 2 puffs)**	**(Example: "Twice Daily")**
_____	_____		_____
_____	_____		_____
_____	_____		_____

Medical Consent Authorization:

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

Name & Signature of Authorized Parent or Guardian Phone Date Signed