

**SOLANO AQUATIC SEA OTTERS
HEALTH & MEDICAL RELEASE FORM**

(Effective February 10, 2010, all swimmers must have a signed completed form on deck to swim. Red boxes are required)

SWIMMER'S NAME _____

M F Birthday: _____ Age: _____ Weight: _____ Height: _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____ Text allowed

E-Mail _____

My Phone Number while named swimmer is at practice (if different from above) (____) _____

Person to contact in the event I cannot be reached _____

Phone number of emergency contact person (____) _____

Person to contact in the event I cannot be reached _____

Phone number of emergency contact person (____) _____

Person to contact in the event I cannot be reached _____

Phone number of emergency contact person (____) _____

HEALTH & GENERAL HISTORY

If the swimmer should be restricted from any activity please note: _____

If the swimmer will be taking medication during practice, please indicate name of drug(s) and dosage (use back for more space):

Please identify any medical condition or medical history that would require special attention:

I hereby certify that the named swimmer is in good health and fully able to participate in all activities of swim practice and that I know of no restrictions, physical impairments, or any other facts, which in any manner limit his/her participation in such a practice:

Signed: _____ Date: _____

ALLEGRIES & DRUG REACTIONS

ALLERGIES:

DRUG REACTIONS:

Physician's Name: _____ Telephone (____) _____

Dentist's Name: _____ Telephone (____) _____

HEALTH INSURANCE INFORMATION

Carrier Name: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Preferred Hospital: _____

I, the parent (guardian) of _____, give permission for the named swimmer to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I will be financially responsible for any medical attention needed during meet or resulting from an illness/injury received at any practice or meet. My medical insurance shall be the insurance coverage for any medical treatment. I further agree that my child can receive over the counter remedies. (Tylenol, Sudafed, etc.)

_____ Please initial here if you DO NOT want your child to receive over the counter medications.

Parent/Guardian Signature _____ **Date:** _____