

## Authorization for Medical Treatment

In the event my son/daughter \_\_\_\_\_ is injured or becomes ill during the period of September 1st 2006 to September 1st 2007, 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 CLEARLY -

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 \_\_\_\_\_