



Medical Release Form

Swimmers Full Name: _____
Last First Middle

Date of Birth: _____

Parent or Guardian: _____

Home Phone: _____ Cell or work phone: _____

Emergency contact/name and phone number: _____

Allergies: _____

Doctor: _____ Phone # _____

Dentist: _____ Phone # _____

Medical Insurance Carrier: _____

Policy Number: _____ Group Number: _____

I/we, the undersigned parent or guardian of _____, a minor, authorize the Osprey Aquatics Swim Team coach, coordinator, adult chaperone or agent(s) to obtain any x-ray, anesthetic, medical, surgical, diagnosis or treatment deemed advisable and obtained by any licensed physician or surgeon, whether in his office or in a licensed hospital when parent or guardian cannot be immediately contacted. This authorization is given in advance to empower the agents to consent to such treatment as the physician may deem advisable, (see section 25.8 of the civil code of California).

Parent/Guardian Signature: _____

Date: _____

Does your child have any of the following conditions?

- _____ diabetes
- _____ asthma
- _____ heart disease
- _____ fainting spells
- _____ epilepsy
- _____ headaches
- _____ convulsions
- _____ frequent nosebleeds
- _____ other

Please explain the extent of their condition and any action that should be taken if they experience this condition while at swimming.

Is your child allergic to insect stings? _____ yes _____ no

If yes, what specific actions should be taken?

The above information is being requested so that the coaches are advised of any health conditions that may arise while your child is at swim practice. If you have any concerns about the information requested please speak with Head coach Brian Bolster. The above information will be shared with the coaches and myself, otherwise it will be confidential.