Inland Empire Zones/All Star Team

Medical Declaration and Emergency Contact Form

PARTICIPANT FIRST NAME:_____M.I.____LAST:_____

DOB:_____/_____/_____ M F

PARENT/GUARDIAN #1*:_____CELL PHONE #:_____

PARENT/GUARDIAN #2*:_____CELL PHONE #:_____

EMERGENCY CONTACT #1:_____RELATIONSHIP:_____

CELL PHONE #:_____

EMERGENCY CONTACT #2:_____RELATIONSHIP:_____

CELL PHONE #:_____

INSURANCE PROVIDER:_____PHONE:_____

ADDRESS:_____

GROUP #_____ID#_____

MEDICAL CONDITIONS:_____

MEDICATIONS:_____

ALLERGIES:_____

DIETARY RESTRICTIONS:_____

I certify that (PARTICIPANT PRINTED NAME%) _____ is in good physical condition and has no other known conditions, other than any/all stated above, which would impair participation in the IE ZONE/ALL STAR TEAM PROGRAM.

In case of injury, I, (PARENT/LEGAL GUARDIAN PRINTED NAME%) _____, hereby give permission for Inland Empire Swimming and its authorized personnel to act on my behalf in seeking MEDICAL TREATMENT for (PARTICIPANT PRINTED NAME%) _____ from any licensed medical professional or licensed medical organization if such treatment is deemed necessary. I give my permission to those administering MEDICAL TREATMENT to do so using methods deemed necessary. I hereby ABSOLVE Inland Empire Swimming and its authorized personnel from any and all LIABILITY while acting on my behalf in this regard.

PARTICIPANT SIGNATURE%:_____DATE:_____

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

*Only required for PARTICIPANTS under the age of 18.

%For Coaches and Chaperones, please print your own name for both PARTICIPANT and PARENT/LEGAL GUARDIAN since those over 18 are their own legal guardians. Please provide PARTICIPANT SIGNATURE and DATE only; ignore PARENT/GUARDIAN SIGNATURE.