

CENTRAL OHIO SWIMAMERICA EMERGENCY MEDICAL RELEASE FORM
(sign and bring to first lesson)

I (we), _____, parent(s) of
(print name(s))

the swimmer(s) listed below grant Jim Peterfish, COSA Program Director, or any COSA supervisor, in our absence, to authorize medical/dental treatment as advised by a licensed physician/dentist, and/or transport by ambulance when all reasonable attempts have been made to contact us while my (our) child(ren) is (are) under the direct supervision of such coach.

Parent(s) Signature Date _____

Emergency Information (please, include as much information as available)

Athlete's Home Phone _____
Father's Cell Phone _____ Name _____
Father's Work Phone _____
Mother's Cell Phone _____ Name _____
Mother's Work Phone _____
Doctor's Phone _____ Name _____
Dentist's Phone _____ Name _____
Other Emergency contact _____ Name _____

Insurance Info: (or, copy of insurance card)

Company _____ Member Number _____ Ph. No. _____

Swimmer #1 Name _____ DOB _____

Medications currently being taken: _____ Duration: _____

Conditions or abnormalities necessary for medical professionals to know during emergency: _____

Allergies: _____

Swimmer #2 Name _____ DOB _____

Medications currently being taken: _____ Duration: _____

Conditions or abnormalities necessary for medical professionals to know during emergency: _____

Allergies: _____

Swimmer #3 Name _____ DOB _____

Medications currently being taken: _____ Duration: _____

Conditions or abnormalities necessary for medical professionals to know during emergency: _____

Allergies: _____