

## Niskayuna Rowing Emergency Medical Authorization

\_\_\_\_\_  
Last Name First Name Gender  F  M

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Mailing Address

Grade: \_\_\_\_ School: \_\_\_\_ (or) Adult: \_\_\_\_ Most recent team: MB MG F/NB F/NG VB VG Other \_\_\_\_ None

\_\_\_\_\_  
Parent/Guardian Name If an Adult: Name of Contact in case of emergency If a Student:

Phone: Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

\_\_\_\_\_  
Other Parent/Guardian Name If an adult: Other Name of Contact in case of emergency If a student:

Phone: Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

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I understand that participating in athletic activities implies risk of injury. I give my son/daughter \_\_\_\_\_  
permission to participate in Niskayuna Rowing Training Program. Or, as an adult participant, I, \_\_\_\_\_,  
am aware of and acknowledge this potential risk.

\_\_\_\_\_  
Parent/Guardian of Student Signature Date

\_\_\_\_\_  
Participant (Student or Adult) Signature Date

### CONSENT OF PARENT/GUARDIAN OF STUDENT OR ADULT PARTICIPANT FOR EMERGENCY TREATMENT:

In the event that reasonable attempts to contact me (or my emergency contacts) have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the doctors listed below or, in the event the designated preferred doctor is not available, by another licensed physician or dentist and to be transferred to: \_\_\_\_\_ or any hospital reasonably accessible.

\_\_\_\_\_  
Parent/Guardian of Student or Adult Participant Signature Date

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Facts concerning the participant's (child or adult) medical history including allergies, medication being taken and any physical impairments to which a physician should be alert: \_\_\_\_\_

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. THIS AUTHORIZATION ALLOWS RELEASE OF PERTINENT MEDICAL INFORMATION TO COACHES AND ATHLETIC TRAINERS.

NOTE: FNR and its coaches are not responsible for contact lenses/glasses that are displaced or damaged during participation in Niskayuna Rowing Training Programs.