

Kaiserslautern Kingfish Swim Team Emergency Medical Treatment Authorization and Trip Permission

I, _____, (Print Name of Parent, Guardian) certify that to the best of my knowledge my child

_____, (Print Name of Swimmer), _____, (Date of Birth)

is in good health and has no health-related condition that could make it unsafe for him/her to participate in physical training and competitive swimming. I have attached a physician's medical evaluation for any known conditions.

Additionally, should my child require medical attention and I cannot be reached to make arrangements for emergency medical attention, I authorize the staff and / or coaches of the Kaiserslautern Kingfish Swim Team to take my child,

to _____ (Print Name of Physician or facility)

or to the nearest emergency medical facility. If the named physician is not available, I authorize the staff and coaches to obtain emergency medical attention and treatment for my child at a hospital or clinic of their choice. I give consent to the hospital or clinic, and physicians to render the necessary emergency treatment to my child. I further authorize staff and / or coaches of the Kaiserslautern Kingfish Swim Team to administer basic first aid to treat minor injuries.

I also grant permission for my minor child as a member of the Kingfish Swim Team, to accompany the team to European Forces Swim League (EFSL) 2009-2010 swim meets, to include overnight meets away from the Kaiserslautern Military Community. ***Swimmers must be accompanied by their parent or a parent designated in writing, when traveling with the Kingfish swim team.*** While away, my child and I understand and agree that they will obey the ***Swim Team Code of Conduct***, the ***Team Handbook*** and will follow the directions of the Head Coach, Assistant Coaches and Parent Chaperones, and Bus Monitors who accompany the team.

Unless revoked or terminated, this authorization will expire on February 28, 2011.

SIGNATURE _____ DATE _____

Sponsor's Name: _____ SSN: _____ Unit: _____

Emerg. Tel. Num.: Work _____ Home _____ Cell _____

Sponsor's Spouse, Name _____ Work/Cell _____

Friend _____ Friend Phone _____

Known Drug Allergies: _____ Regular Medications: _____

Known Medical Conditions or concerns: (explain on back if more room required) _____

Past or present problems: Please circle appropriate response.

Eye problems, wears glasses or contacts	yes	no	Kidney Disease	yes	no
Loss of consciousness, fainting, epilepsy	yes	no	Diabetes	yes	no
Wears braces	yes	no	Migraine Headaches	yes	no
Asthma or breathing problems	yes	no			
Heart problems	yes	no			