



## Permission and Consent to Medical Care

I give my permission for my children listed below to participate in the Mercerwood Shore Club Winter Swim Team ("MSC Team"). I agree that neither Mercerwood Shore Club (the "Club"), nor the employees of the Club, nor the parent volunteers assisting the MSC Team, nor the Club Board of Directors shall in any way be held liable for any accident or injury in any way received on account of or while engaged in any activity sponsored by the MSC Team. I further agree that neither the Club, nor any of its employees or volunteers, nor the board members of the Club shall be held responsible for the payment of any bills rendered for medical services as a result of such accidents or injuries.

**What happens.....if your child needs emergency treatment in your absence?** If your child needs emergency treatment and is under the age of 18, hospitals are required by law to reach you for authorization to medically treat your child, except in the case of truly life threatening situations. Only a parent or legal guardian may give this authorization.

If you are not available to sign the consent, all attempts have been made to reach you, and you cannot be reached within a reasonable time, you can ensure emergency treatment for you child by using this PERMISSION and CONSENT TO MEDICAL CARE form.

The undersigned parent or legal guardian hereby agrees to the terms of the first paragraph above and authorizes all medical, surgical, diagnostic, and hospital procedures as may be performed or prescribed by a treating physician for child / children identified below if I cannot be reached in the case of any emergency.

\_\_\_\_\_ (Signature of parent or legal guardian) \_\_\_\_\_ (Date)

### Please complete the following information:

Child's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

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Parents/Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail Address(es): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone(s): \_\_\_\_\_

Work Phone(s): \_\_\_\_\_

Emergency Contact/Phone: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**COMPLETE MEDICAL INFORMATION ON EACH CHILD ON REVERSE SIDE**

**MEDICAL INFORMATION FOR EACH CHILD**

Child's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

**List any medical or physical limitations child may have:**

- |                                    |  |  |  |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Glasses or Contacts       | <input type="checkbox"/> Surgery within the year       | <input type="checkbox"/> Heart Murmurs   |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding tendencies       | <input type="checkbox"/> Head injuries within the year | <input type="checkbox"/> Serious Illness |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Fractures within the year | <input type="checkbox"/> Dental Braces or Bridges      | <input type="checkbox"/> Seizures        |

If any of the above were checked, please specify here: \_\_\_\_\_

Special Instructions relative to seizures: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

Other: \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

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