



Medical Authorization and History

Print Name of Rower

Print Name of Parent or Legal Guardian

Relationship to Rower

I hereby authorize and consent to the administration of any and all medical, dental, and surgical examinations or operations and treatment or all other related care, including the administration of drugs, tests, anesthesia and/or blood transfusions to the above named minor person that may be ordered by a physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above named minor person to the hospital.

Parent or Legal Guardian Sign here _____

Date _____

I understand that Community Rowing Inc. and its officers, employees and volunteers assume no financial obligation or liability in the case of my child's accident or illness. If I, or anyone on my or my child's behalf makes a claim against Community Rowing Inc. or their officers, employees or volunteers arising from to my child's participation in Community Rowing Inc. programs, I agree to indemnify and hold them harmless from any litigation expenses, attorneys' fees, loss, liability, damage or costs they may incur due to the claim made against any of them, whether the claim is based on their negligence or otherwise. I sign this agreement on my child's behalf, my behalf and on behalf of my personal representatives, assigns, heirs and next-of-kin. I hereby give my permission for emergency treatment for my child and assume financial responsibility for such treatment.

Parent or Legal Guardian Sign here _____

Date _____

*** Please continue with medical history on the following page. ***

Revised 3/12/14

Rowers Name _____

Date _____

First person to contact in an emergency:

Name _____

Relationship to Rower _____

Phone (day) _____

Phone (eve) _____

Phone (cell) _____

Alternate person to contact in an emergency:

Name _____

Relationship to Rower _____

Phone (day) _____

Phone (eve) _____

Phone (cell) _____

Physician (include Name, Phone Number & Address)

Health Insurance Co. _____

Medical Policy # _____

Asthma Yes _____ No _____ Does your child carry an inhaler? _____

Usual cause of asthma occurrence _____

Allergies _____

Medications _____

Diabetes Yes _____ No _____ Frequency of dosage and type of Insulin _____

Medical Concerns _____