Year: 2021 **STUDENT'S LAST NAME**_____

EMERGENCY MEDICAL FORM

Student's Name: _____

Address: _____
Street City Zip Code

PURPOSE: To authorize the provision of emergency treatment for children who become ill or injured while under Bay City Rowing Club authority.

_____ __WORK or __DAYTIME PHONE_____
__Mother ____Stepmother Name (check one) (check one)
CELL _____

_____ __WORK or __ DAYTIME PHONE _____
__Father ____Stepfather Name (check one) (check one)
CELL _____

_____ __WORK or __ DAYTIME PHONE_____
Legal Guardian's Name (check one)
CELL _____

NAME of Other Emergency Contact (in case above cannot be reached)

Name _____ Relationship _____

Phone _____ Cell Phone _____

MEDICAL HISTORY

Medical Facts - Please list all facts concerning the child's medical history including allergies, medications taken, and any physical impairments or mental health issues to which a physician or Club coaches should be alerted.

Covid19 Vaccination status: fully, partially or not vaccinated (**circle one**) Date of 2nd vaccine_____

_____

_____

_____

_____

_____

_____

_____

TO GRANT CONSENT FOR MEDICAL TREATMENT:

I, _____, the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that Bay City Rowing Club personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

_____ _____
Signature of Parent/Guardian Date