

Year: 2026 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.**

\_\_\_\_\_  
Mother Stepmother Name (check one) WORK or DAYTIME PHONE  
(check one)

CELL \_\_\_\_\_

\_\_\_\_\_  
Father Stepfather Name (check one) WORK or DAYTIME PHONE  
(check one)

CELL \_\_\_\_\_

\_\_\_\_\_  
Legal Guardian's Name WORK or DAYTIME PHONE  
(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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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