

CORONADO AQUATICS CLUB

FORM # R 2 - PARTICIPANT MEDICAL RELEASE

GENERAL INFORMATION:

ATHLETE'S LAST NAME:	ATHLETE'S AGE:
FIRST NAME:	DATE OF BIRTH:
MIDDLE INITIAL:	ATHLETE'S SOC. SEC. #
ADDRESS:	PHONE:
CITY & ZIP:	ADDITIONAL PHONE:
FATHER'S NAME:	MOTHER'S NAME:
HOME PHONE (IF DIFFERENT):	HOME PHONE (IF DIFFERENT):
WORK PHONE:	WORK PHONE:
CELL PHONE:	CELL PHONE:
ATHLETE'S EMERGENCY CONTACT:	
RELATIONSHIP:	EMERGENCY PHONE:
MEDICAL / INSURANCE INFORMATION:	
FAMILY PHYSICIAN:	PHYSICIAN PHONE:
MEDICAL ALERTS:	
<input type="checkbox"/> ASTHMA / INHALER	<input type="checkbox"/> BEE STINGS / STINGRAYS
<input type="checkbox"/> FOOD / ENVIRONMENTAL ALLERGIES	<input type="checkbox"/> DRUG ALLERGIES
<input type="checkbox"/> OTHERS:	
DATE OF LAST TETNUS SHOT / BOOSTER:	
INSURANCE INFORMATION:	
INSURANCE COMPANY:	INSURANCE POLICY NO.:
POLICY HOLDER'S NAME:	GROUP NO.:
IS THIS AN HMO? <input type="checkbox"/> YES <input type="checkbox"/> NO	PAY FOR PRESCRIPTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO
PARENTS' / GUARDIANS' CONSENT STATEMENT:	
<p>By my signature and in my absence, I authorize and hereby grant permission to any Coronado Aquatics Club coach or administrator and / or any hospital as agent(s) for the undersigned to consent, in advance of any specific diagnosis, to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is rendered under the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and shall remain in effect, unless sooner revoked in writing delivered to said agent(s) until the end of the current school year.</p>	
PARENT / GUARDIAN SIGNATURE: X _____	DATE: mm _____ dd _____ 2004