**Selinsgrove Swim Team**
**SST Waves**

---

# MEDICAL RELEASE

**In case of emergency, if family physician/dentist cannot be reached, I hereby authorize my child to be treated by certified emergency personnel (i.e. – EMT, First Responder, ER Physician).**

Family Physician:______________________________ Phone: (    )______________

Physician Address:______________________________ City:______________

Hospital Preference:______________________________________________

Family Dentist:______________________________ Phone: (    )______________

Dentist Address:______________________________ City:______________

Health Insurance Company:______________________________ Phone: (    )______________

Subscriber:________________ Policy #:________________ Group #:______________

**If parent(s)/guardian(s) cannot be reached in case of emergency, contact:**

| Emergency Contact Name | Phone | Relationship |
|---|---|---|
| | | |
| | | |

**Please list any allergies/medical problems, including those requiring maintenance mediations (diabetic, asthma, seizures, etc.):**

| Illness | Medication | Dosage | Frequency |
|---|---|---|---|
| | | | |
| | | | |

**List all allergies and reactions:**

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

If needed, can your child take Tylenol, Advil, or Tums: ☐Yes ☐No     Date of last Tetanus:______________

**The purpose of the above listed information is to ensure that medical personnel have details of any medical problems which may interfere with or alter treatment.**

**My child and I are aware that participating in swimming is potentially a hazardous activity. I assume all risks associated with participation in this sport. All such risks to my child are known and understood by me.**

**Parent/Guardian Signature:______________________________ Date:______________**