



**Rower Medical Authorization and Information 2017-2018**

Rower's Name: \_\_\_\_\_

School: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_

Height \_\_\_\_\_

**Primary Household Address:**

Address (please print): \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Home Ph (\_\_\_\_) \_\_\_\_\_

**Parent(s) or Guardian(s) Name(s):**

Parent 1 name (please print): \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

Parent 1 e-Mail Address (please print): \_\_\_\_\_

Parent 2 name (please print): \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_

Parent 2 e-Mail Address (please print): \_\_\_\_\_

Rower e-Mail Address (please print): \_\_\_\_\_

Rower's cell: (\_\_\_\_) \_\_\_\_\_

If your rower has two households, please provide further information below:

Name(s) (please print): \_\_\_\_\_

Address (please print): \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

e-Mail Address: \_\_\_\_\_

**Emergency Medical Information**

Rower's Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

**Emergency Medical Information (Cont.)**

In-state hospital preference: \_\_\_\_\_

Medical History:

Rowers who need inhalers, epi pens, glucose and/or insulin must bring these to practice! Please let us know if you have any learning differences, ADD or receive learning accommodations at school. Our coaches will work with your learning style to make sure that your rowing experience is a successful one. Please provide as much information as possible on how you learn best.

Allergies: \_\_\_\_\_

Prescription medications: (including insulin, epi pens, ADD and ADHD medications)  
\_\_\_\_\_

Known Medical Conditions/Learning Issues/Comments:  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information: (Please attach a copy of your insurance card-front and back)**

Insurance Carrier: \_\_\_\_\_  
Policy / Group #: \_\_\_\_\_  
Policy holder's name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance telephone: \_\_\_\_\_  
Insurance address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Information:

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Tel: (\_\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_\_) \_\_\_\_\_  
2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Tel: (\_\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_\_) \_\_\_\_\_

**Authorization to Treat a Minor / Medical & Liability Release**

I am fully aware of and appreciate the risks and other damages and losses associated with participation in this rowing program. I agree that (a) the Mile High Rowing Club: (b) associated coaches, volunteers, board members and parents, as a group or as individuals, assume no liability or financial obligation for any loss, accident or illness incurred by the above named participant in the course of his/her association with the program. The above named participant/rower is in good physical condition with no limitations. There are no known diseases, mental or physical conditions or medications taken that could result in the participant being harmed by this program. While I understand that hospital / physician / coaches will try to contact me, as the parent/guardian of the above named participant/rower, I authorize in my absence the emergency evaluation and treatment deemed necessary by the attending physician in the case of an accident or illness.

I (we) the undersigned parent(s) or legal guardian(s) of the rower,/participant listed below, a minor, do hereby authorize and consent for medical treatment as deemed necessary by an emergency room physician. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. I understand that I am responsible for the costs of all medical treatment.

Name of Participant/Rower: \_\_\_\_\_

**Parent/Guardian Acknowledgement:**

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_