SLRC Medical Care Consent

Rower's name: ______________________ Home phone: (   ) ______________________

Grade: ________ Date of birth: ______________ Age: ________ Gender: ______________

Parent/Guardian Name: ______________________ Day Phone: (   ) ______________________

Work Phone: (   ) ______________________ Cell Phone: (   ) ______________________

Address: ____

Parent/Guardian Name: ______________________ Day Phone: (   ) ______________________

Work Phone: (   ) ______________________ Cell Phone: (   ) ______________________

Address: ____

Listed below are any known allergies, special medical conditions and current medication used by my child:

Allergies (to bee stings, medications, etc.): ____

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Medical Conditions: ____

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Medications: ____

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Acknowledgment of risk and consent for treatment: I acknowledge that there are risks inherent in any children's sports program, including but not limited to injury or death arising from: participation in rowing activities, child's failure to follow instructions of coaches/chaperones; communicable illness; and independent acts of third parties not under the control of coaches/chaperones. I acknowledge that all risks cannot be prevented, and assume those beyond the control of St. Louis Rowing Club (SLRC). In order to minimize risks to my child or other participants, I will take responsibility to see that my child is prepared for all activities and in good health each day of practice and/or regatta.

In case of medical emergency, I understand that every reasonable attempt will be made to contact me, my family physician, or the emergency contact name below. However, in the event that I or my named contacts cannot be reached, I give my permission to the head coach (or his/her designee) at SLRC to secure emergency medical treatment for my child. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance. This acknowledgment applies to all SLRC events, practices and regattas in which my child participates.

Emergency Contact: ______________________ Phone: (   ) ______________________
(other than parent/guardian)

Health Insurance Co. & Policy No.: ______________________ Phone: (   ) ______________________

Family Physician: ______________________ Phone: (   ) ______________________

Preferred Hospital in St. Louis: ____

I have attached a copy of front and back of his/her medical insurance card.

______________________ ______________________ ______________

Parent/Guardian Name (Please Print) Signature (required) Date