Dodgeville Dolphins Swim Team
Emergency Contact Form/Consent to Treat

Family's Last Name:____

1st Child's Name:____________________________Age:________DOB:_____/______/_____

Allergies:____

____

Medications:____

____

____

2nd Child's Name:____________________________Age:________DOB:_____/______/_____

Allergies:____

____

Medications:____

____

____

3rd Child's Name:____________________________Age:________DOB:_____/______/_____

Allergies:____

____

Medications:____

____

____

In case of an emergency Parents or Guardians will be contacted first:

Parent/Guardian:____

Address:____________________________________City:___________________Zip:________

Hm Ph:___________________Cell Ph:___________________Wk Ph:____________________

Health Insurance:____________________________________Policy #:___________________

This is to certify that on this date, I ___________________________________, as parent or guardian of ______________________________ (swim team participant), give my consent to Swim Team Coaching Staff to obtain medical care from any licensed physician, hospital, or clinic for any of the above mentioned participants, for any injury or illness that could arise from participation in and at Swim Team events.

Parent or Guardian Signature:____Date:_________________

OVER

MEDICAL HISTORY FORM

Alternate: WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name: ______________________________________ **Relationship:** _______________________

Daytime Ph: ________________ **Evening Ph**: ________________**Cell Ph**:____________________

Name: ______________________________________ **Relationship:** _______________________

Daytime Ph: ________________ **Evening Ph**: ________________**Cell Ph**:____________________

Physician's Name: ____

Daytime Phone: _________________________ **Evening Phone**: ___________________________

Hospital of Choice: ___________________________________**Ph:**_______________________

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is "yes", please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have your child had (or presently has) any of the following? Circle One

	1st Child	2nd Child	3rd Child
name of child:	________	________	________
Head injury (concussion, skull fracture)	Yes No	Yes No	Yes No
Fainting spells	Yes No	Yes No	Yes No
Convulsions/epilepsy	Yes No	Yes No	Yes No
Neck or back injury	Yes No	Yes No	Yes No
Asthma	Yes No	Yes No	Yes No
High blood pressure	Yes No	Yes No	Yes No
Kidney problems	Yes No	Yes No	Yes No
Hernia	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No
Heart murmur	Yes No	Yes No	Yes No
Allergies	Yes No	Yes No	Yes No

Please specify: ____

Injuries to:

	1st Child	2nd Child	3rd Child
name of child:	________	________	________
Shoulder	Yes No	Yes No	Yes No
Knee	Yes No	Yes No	Yes No
Ankle	Yes No	Yes No	Yes No
Fingers	Yes No	Yes No	Yes No
Arm	Yes No	Yes No	Yes No

Other:____

Impaired vision: 1st Child - Yes / No 2nd Child – Yes / No 3rd Child – Yes / No

Impaired hearing: 1st[t]Child – Yes / No 2nd Child - Yes / No 3rd Child – Yes / No

Other: ____

Has your child had a recent tetanus booster? 1st Child – Yes / No 2nd Child - Yes / No 3rd Child - Yes / No

If so, when? (Date) 1st child - _______________ 2nd child - _______________ 3rd child - _________________

Has the doctor placed any restrictions on this activity? 1st Child-Yes / No 2nd Child- Yes / No 3rd Child- Yes / No

Explain:____