

**EMERGENCY MEDICAL AUTHORIZATION**  
**Gamble Nippert YMCA Swim Team**  
**3159 Montana Avenue, Cincinnati, OH 45211**  
**\*\* Complete One Form For Each Swimmer \*\***

Name of Swimmer _____	Date of Birth _____	Sex _____
Street Address _____		
City _____	State _____	Zip _____
Name of Mother _____		Phone _____
Name of Father _____		Phone _____
Place of Birth _____		

**Purpose:**

**To enable parents and guardians to authorize the provision of emergency treatment for a child who becomes ill or injured while participating with the Gamble Nippert YMCA Swim Team, when parents or guardians cannot be reached.**

To Grant Consent: In the event reasonable attempts to contact me at (phone) \_\_\_\_\_ or (other parent) \_\_\_\_\_ at (phone) \_\_\_\_\_ have been unsuccessful, I hereby give my consent for 1) administration of any treatment deemed necessary by Dr. \_\_\_\_\_ at (phone) \_\_\_\_\_, preferred doctor, or Dr. \_\_\_\_\_ at (phone) \_\_\_\_\_, preferred dentist, or by another licensed physician or dentist if the preferred practitioner is not available; and 2) transfer of the athlete to \_\_\_\_\_, preferred hospital, or any hospital accessible.

Name of Insurance Co. \_\_\_\_\_ Carrier: \_\_\_\_\_ ID# \_\_\_\_\_

**Note:** This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for surgery, are obtained prior to such surgery.

**ATHLETE HISTORY**

1. Has athlete ever had hospitalization, surgery, injury or serious medical illness?  YES  NO
2. Is athlete now under the care of a physician?  YES  NO
3. Is athlete taking any medication?  YES  NO
4. Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports?  YES  NO
5. Does athlete have any known allergies to medications?  YES  NO If yes, please specify: \_\_\_\_\_
6. Does athlete wear glasses or contact lenses?  YES  NO If yes, date of last exam: \_\_\_\_\_
7. Has athlete ever blacked out or lost consciousness during physical activity?  YES  NO  
If yes, please specify: \_\_\_\_\_

Facts concerning the athlete's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/ Guardian \_\_\_\_\_

**Please return this form with Registration Form to: Sue Walker, Treasurer**