



UPAC SWIM CLUB MEDICAL RELEASE FORM

To UPAC Board and Staff:

I declare that I am the parent or legal guardian of: _____, a minor, age: _____. I have full custody and control of the child. In the event that my child is injured or should require medical attention, I hereby authorize a UPAC staff member or any other UPAC volunteer to secure necessary medical treatment for my child. I further acknowledge that I will be responsible for any medical fees /costs associated with my child's medical treatment. If possible, confirmation of this authorization should be made with me prior to treatment or transport by calling me at the provided numbers below.

In case I cannot be reached, or in case of an emergency, medical treatment as described above may proceed without further authorization.

Signed: _____ Date: _____

MEDICAL AND FAMILY INFORMATION

Athlete: _____ Birthdate: _____

Mailing Address: _____

City: _____ Zip Code: _____

Fathers Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mothers Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Person to notify in case of emergency:

1. _____ Phone: _____

2. _____ Phone: _____

Doctor: _____ Phone: _____ Hospital: _____

Medical Insurance Company _____ Medical Ins. Number: _____

Special Instructions/ALLERGIES: