



P. O. Box 13849
Arlington, Texas 76094

Consent for Medical Treatment

Legal First Name

Legal Last Name

Legal Middle Name

Preferred Name

Birth date (mm/dd/yy)

Current Age

Female

Male

Medical Doctor's Name

Medical Doctor's Phone Number

Dentist's Name

Dentist's Phone Number

In case of an emergency and the parents or guardian cannot be reached, please contact:

Name

Phone

Please list any ongoing medical conditions and medications for any condition that you feel is necessary for the coaching staff to be aware of: _____

Please list any medications that your child is allergic to: _____

As the parent or guardian of the above-named swimmer, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature

Date