

**MEDICAL INFORMATION & EMERGENCY RELEASE (CONFIDENTIAL)**  
**(ONE PER SWIMMER)**

Swimmer's Name \_\_\_\_\_

Parents' Names: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parent's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

1. In the space provided below, list any pertinent health or medical information and instructions or special problems (allergies, tetanus booster dates, drug allergies, asthma, prescriptions, diabetic, head injuries, weight issues, fainting, etc.)

\_\_\_\_\_

2. Aside from yourselves, (the parents of the Swimmer), please indicate (in order), those individuals that you would like the coaches to contact should there be an emergency involving your child:

\_\_\_\_\_

3. Swimmer's Doctor: \_\_\_\_\_ Phone \_\_\_\_\_

4. Swimmer's Dentist: \_\_\_\_\_ Phone \_\_\_\_\_

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I (we) hereby give our permission for \_\_\_\_\_  
to participate in practice and travel with Hastings Area Swim Team to local and out-of-town meets throughout the current swim season. Although I expect all reasonable safety procedures to be followed, I will not hold the coaches of HAST nor any chaperone or volunteer working with or traveling with the group personally liable for any accident which may occur.

In case of a minor emergency (cuts, scratches, headache, etc.), I (we) give permission to the coaches or chaperones to treat these as they deem necessary. In the event of a more serious emergency, I give permission for it to be handled in the best manner as determined by the chaperones or coaches of HAST until I am able to be contacted.

I recognize the possibility of physical injury associated with swimming and in consideration for HAST accepting the registrant(s) for its swim programs and activities, I hereby release, discharge and/or otherwise indemnify HAST; its affiliated organizations; the employees, coaches and associated personnel; including the owners of the facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

**TO THE ATTENDING PHYSICIAN OR HOSPITAL:**

Permission is hereby granted for you at the discretion of the coaches or chaperons of HAST to perform whatever care is necessary for the welfare of my child until such time as you are able to reach me personally.

**INSURANCE INFORMATION (must be complete)**

Subscriber's Name (parent): \_\_\_\_\_

Insurance Company: \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Coverage (i.e. medical, dental): \_\_\_\_\_

Insurance authorization phone number: \_\_\_\_\_

Preferred local hospital: \_\_\_\_\_

_____	_____
Parent or Guardian Signature	Date