SOUTHWEST ULTIMATE FRISBEE CLUB (MÜS)

Medical Authorization Form

(Spring 2017)

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for their children who are injured or become ill while under the authority of volunteer Coaches, Faculty Advisor, and Chaperones of the club who have completed, signed and submitted the Chaperone form for the Southwest High School Ultimate Frisbee Club, in the event the parents or guardians cannot be reached.

This acknowledges that we, the undersigned, parent(s) or legal guardian(s) of [Name of participant] _____ recognize the potentially hazardous nature of the sport of ULTIMATE and that an injury might be sustained. These injuries include but are not limited to PERMANENT DISABILITY, BLINDNESS, PARALYSIS AND DEATH. In the event of such an injury to my child and we (I or my spouse or the child's guardian) cannot be contacted, we give permission to qualified and licensed EMTs, physicians, paramedics, and/or other medical or hospital personnel to render such treatment.

We (I) release Southwest Ultimate Frisbee Club, their employees, agents, volunteers and assigns from any personal injuries caused by or having any relation to this activity. We (I) understand that this release applies to any present or future injuries or illnesses and that it binds my heirs, executors and administrators.

This release form is completed and signed of my own free will and with full knowledge of its significance. I have read and understand all of its terms.

Parent or Guardian: _____
Name Printed Signature Date

Parent or Guardian: _____
Name Printed Signature Date

Family Physician: _____
Name Printed Address Phone

Preferred Hospital: _____

Child's Medical Insurance Carrier: _____
Name Phone

Emergency Contact: _____
Name Address Phone

Specific facts concerning child's medical history including allergies, medications being taken, chronic illness or other conditions which a physician should be alerted to:

_____

_____

_____

PARENT/Guardian Signature_____Date_____