

# **SwimStrong Medical Emergency Form**

Please return to SwimStrong along with your registration, signature and contact, volunteer form and payment.

Swimmer's Name \_\_\_\_\_  
Last Name First Name M.I.

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relative/Friend's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

In the event reasonable attempts to contact me at \_\_\_\_\_ OR \_\_\_\_\_  
Phone Number Other Parent/Guardian

at \_\_\_\_\_ have been unsuccessful, I hereby give my consent for:  
Phone Number

(1) The administration of any treatment deemed necessary by Dr. \_\_\_\_\_  
Preferred Physician  
or Dr. \_\_\_\_\_, or, in the event the designated preferred practitioner is  
Preferred Dentist  
not available, by another licensed physician or dentist; and

(2) the transfer of the child to \_\_\_\_\_ or any hospital reasonably  
Preferred Hospital  
accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments and/or social/emotional health concerns to which a physician should be alerted:

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\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Please return completed form to: SwimStrong PO Box 360524 Strongsville, OH 44136