Western Reserve Rowing Association (WRRA)

EMERGENCY MEDICAL AUTHORIZATION (for participants under 18 years of age)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under WRRA authority, when parents or guardians cannot be reached.

Child's Name: _____

RESIDENTIAL PARENT OR GUARDIAN:

Mother's Name: _____ Daytime Phone: _____ Evening Phone:_____

Father's Name: _____ Daytime Phone: _____ Evening Phone:_____

Other's Name: _____ Daytime Phone: _____ Evening Phone:_____

Name of Relative
or other Caregiver: _____ Daytime Phone: _____ Evening Phone:_____

Child's Address:_____

PART 1 – CONSENT TO TREAT

I hereby give my consent for the following medical care providers and local hospital to be contacted:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

If reasonable attempts to contact me have been unsuccessful, I hereby grant my consent for the administration of any treatment considered necessary by the above named medical professionals, or if the designated practitioner is not available, by another licensed physician or dentist; and the transfer of the child to any hospital reasonably 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 impairment to which a physician should be alerted:

_____

_____

_____ _____

Signature of Parent/Guardian **Date**

PART 2 – REFUSAL TO CONSENT

I do **not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the WRRA to take no action or to:

_____

_____ _____

Signature of Parent/Guardian Date