Kim Hay
2145 Ostman Road
West Linn, OR 97068
503.655.7939 (home)

Cascadia Swimming
Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____

Phone #s: Home: (_____)_____-_____

Work: (_____)_____-_____

Cell: (_____)_____-_____

Other: (_____)_____-_____

Children's Names	List all known Medical Conditions, including, Food Allergies and/or Drug Allergies. In addition, include any and all Over-the-Counter and/or Prescription Drugs Taken Regularly

In an emergency, please contact: _____

Relationship to child/children: _____

Phone #s: (_____)_____-_____ (_____)_____-_____

(_____)_____-_____ (_____)_____-_____

Or contact: _____

Relationship to child/children: _____

Phone #s: (_____)_____-_____ (_____)_____-_____

(_____)_____-_____ (_____)_____-_____

Physicians Name: _____

Address:_____

Phone #s: (_____)_____-_____ (_____)_____-_____

Dentist's Name: _____

Address: _____

Phone #s: (_____)_____-_____ (_____)_____-_____

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Cascadia Swimming
Medical Release Form

Primary Insurance Company: _____

Phone #s: (_____)_____-_____ (_____)_____-_____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID#: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Phone #s: (_____)_____-_____ (_____)_____-_____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID#: _____ Group/Policy #: _____

Statement of Consent:

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____