

## Athlete Rep Consent for Treatment of Minor, Acknowledgement of Risk and Code of Conduct/Travel Policies Acceptance

6/22/16

### ATTACH A COPY OF ATHLETE REP MEDICAL COVERAGE CARD FRONT & BACK

Name of Athlete Rep:	Birthdate:	Home Phone:
Mother's Name:	Mother's Cell Phone:	Mother's Work Phone:
Father's Name:	Father's Cell Phone:	Father's Work Phone:
Physician's Name:	Physician's Phone:	Preferred Hospital:
Emergency Contact Name (other than parent):	Relationship to Athlete Rep:	Emergency Contact Phone:
Dentist Name:	Dentist Phone:	Athlete Rep Cell Phone:
Insurance Company:	Insurance Phone**:	Name of Insured:
Insurance Address:	Group Number:	Policy Number:

\*\*Phone number to obtain authorization for emergency treatment, usually an 800 number.

Allergies (medication, food, plants, insect bites/stings)? Y N If yes, list: \_\_\_\_\_

Medications? Y N If yes, list \_\_\_\_\_

Yes  No Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Asthma: Y N Diabetes: Y N Seizures: Y N Heart Disease: Y N Glasses: Y N Contacts: Y N

List on back any other medical conditions of which we should be aware.

**Authorization to Consent to Emergency Treatment of Minor**

I/We, the undersigned parent(s)/legal guardian(s) of \_\_\_\_\_ a minor do hereby authorize Utah Swimming Western Zone Age Group Championships meet leadership and chaperone as agents for the undersigned to act on my behalf to consent to an emergency transport, x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is advisable, and is to be rendered under the general supervision of any licensed physician and surgeon when the parent or legal guardian cannot be immediately contacted. I/we grant permission to the physician and/or appropriate medical personnel to attend to my child. In addition, I/we grant permission for the physician/meet leadership staff and chaperone to release and receive medical information pertaining to the necessary treatment of my child. This information may be transmitted via telephone, personal interview, electronic mail, postal service, fax or other form of media not listed here. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the agent to give specific consent to any and all such emergency diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This permission will be in effect August 9-14, 2016.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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**Permission/Acknowledgement of Risk for Athletic Participation**

As the parent(s)/legal guardian(s) of the previously named student-athlete, I/we give consent for his/her participation in Utah Swimming's program and athletic events. I know that the risk of injury to my child comes with the participation in sports and during travel to and from meets. My/our signature(s) below indicates permission for my child to participate and acknowledgement of this fact.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Code of Conduct and Travel Policies Acceptance**

I have read and understand the Athlete Rep Code of Conduct and Travel Policies document and hereby agree to abide by the rules of conduct as set forth in Part I and acknowledge that, should I violate any provision in Part I, I will be subject to disciplinary action, as set forth in Part II.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Athlete Rep

\_\_\_\_\_  
Signature of Athlete Rep

\_\_\_\_\_  
Date

**RETURN**

1. This completed form &
2. Copy of medical coverage card  
(front & back)

TO [Name] NO LATER THAN JULY 13,  
2016

Email:

Phone:

Address: