Connecticut Boat Club, Inc.

Medical Authorization

(Please Print)

Participant:_____
Last First Middle

Address: _____
Street City State Zip

Medical illnesses, allergies or limitations participant has regarding active participation in the rowing program that I / we believe the coaches should be aware of:

_____

_____

Medications: _____

Physician: _____
Name Telephone

Dentist: _____
Name Telephone

Insurance: _____
Name of Insurance Provider Policy Number Telephone

During _____'s participation in Connecticut Boat Club's program activities, I / we authorize the CBC coaches and trainers to make decisions and to proceed with any critical medical or surgical treatments deemed necessary, provided an attempt was made to contact us, the parents or guardians, first. In the event that we the parents or guardians cannot be reached, I / we give CBC permission to seek medical attention for the program participant.

Signature:_____
Parent/ Guardian Date

Phone # _____ Cell #_____

Signature:_____
Parent/ Guardian Date

Phone # _____ Cell #_____

The coaches have my/our permissions to give the program participant over-the-counter medications stocked in the medical training kits. Yes or No Initials _____

Additional emergency contacts:

_____
Full Name Contact # Relation to participant

_____
Full Name Contact # Relation to participant