Connecticut Boat Club, Inc.

Medical Authorization

(Please Print Clearly)

Athlete:____
Last First Middle

Address: ____
Street City State Zip

Medical illnesses, allergies or limitations athlete has regarding active participation in rowing 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

Parent Cell #___________________________

Signature :____
Parent/ Guardian Date

Parent 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