

WESTLAKE WAVES SWIM CLUB  
U.S.A. SWIMMING MEDICAL EMERGENCY FORM  
**(Please print clearly)**

Swimmer's Name (Last Name, First Name, Middle initial)

**Home Phone Number**

Street Address

City

Zip

Birth Date

Age

Father's Name

Business Phone

Mom's Cell Phone/Pager

Mother's Name

Business Phone

Dad's Cell Phone/Pager

Physician's Name

Phone number

**E-mail address(es)**

Dentist's Name

Phone number

Emergency friend or relative Name

Phone number

In the event reasonable attempts to contact me at \_\_\_\_\_ or \_\_\_\_\_ at \_\_\_\_\_  
Phone number Other parent/ guardian Phone number

have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by  
Dr. \_\_\_\_\_ or Dr. \_\_\_\_\_ or, in the event the designated preferred

Preferred Physician

Preferred Physician

practitioner is not available, by another licensed physician or dentist; and the transfer of the child to  
\_\_\_\_\_ or any hospital reasonably accessible.

Preferred Hospital

**We must have this form completely filled out and on file for any swimmers to participate in practice.**

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.

Please list any and all facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician or the coaches of the Westlake Swim Club should be alerted:

Signature of Parent or Guardian

**Date**