City of Willard

Parks and Recreation Department

Water Aerobics

Please complete the following information:

FULL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

BIRTH DATE (MM/DD/YYYY):_____

FAMILY PHYSICIAN: _____

PHYSICIAN TELEPHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION (this is VERY important, as we may need to reach someone during the day in case of sudden illness, accident, etc.)

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

RELATIONSHIP: _____

ANY OTHER INFORMATION OR COMMENTS (medication, allergies, etc.)

_____

_____

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and hospitals to be called:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____ Phone: _____

Medical Specialist: _____ Phone: _____

In the event that reasonable attempts to contact my emergency contact listed have been unsuccessful, I hereby give my consent for:

(1) The administration of any treatment deemed necessary by the named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and

(2) The transfer of myself to my preferred hospital or any hospital reasonably accessible

This authorization does not cover major medical surgery unless the medical options of two other licensed physicians or dentists, concurring with the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning my medical history, including allergies, medications being taken, and any other physical impairment to which a physical should be alerted: _____

_____

SIGNATURE: _____ DATE: _____

PART 2: REFUSAL TO CONSENT

I DO NOT give permission for emergency medical treatment for myself. In the event of illness or injury requiring emergency treatment, I wish the program authorities to take the following action: _____

_____

SIGNATURE: _____ DATE: _____