

**2009 Senior Trip  
SOUTHEASTERN SWIM CLUB  
MEDICAL RELEASE FORM**

*AUTHORIZATION BY PARENT(S) FOR ANOTHER TO CONSENT TO  
HOSPITALIZATION, SURGERY, OR OTHER MEDICAL PROCEDURES  
DURING ABSENCE OF PARENT(S)*

Before completing this medical release form, please follow these guidelines:

1. All blanks on the form must be filled out. All blanks not applicable should be indicated N/A (not applicable).
2. Unless there is only one parent with legal custody, or unless the child has a legal guardian, both parents must sign the form for it to be valid.
3. Please date the information as requested.

*Parents' Names* (Please print.)

**Father**

**Mother**

**Date**

**Name**

**Name**

**Address:**

**Home Phone:**

**Business Address:**

**Business Phone:**

*Name of Child(ren)* (Please print.)

First

Last

Birthdate

First

Last

Birthdate

*I/We Hereby Appoint:* Tom Childress, Christian Hanselmann, Mike Netherton, Andy Pedersen, Brenda Zoller, Larry Zoller

as the adult, who during my/our absence, shall be authorized to consent for all reasonable and necessary medical and/or surgical treatment and/or other medical procedures (including by way of illustration and not limitation, administration of anesthesia, blood transfusions, diagnostic tests, etc.) which are required during my/our absence for the named and described minor child(ren) on page one of this document.

I/we understand that in such case, reasonable attempts would first be made to contact me/us, time and conditions permitting, and that in any event, I/we will be notified of action taken as soon as reasonably possible. I/we can be contacted at the home and/or business address(es) and phone number(s) on page one of this document. During an absence from either of these locations, I/we can be contacted at the following address and phone number:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

Without in any manner limiting the foregoing appointment and authorization, if circumstances permit, I/we would like to have our doctor consulted in connection with such medical and/or surgical treatment and/or special procedures.

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Phone

*Medical History*

Allergies, if any, including medication \_\_\_\_\_  
\_\_\_\_\_

Chronic or existing diseases or medical problems (e.g. diabetes) \_\_\_\_\_  
\_\_\_\_\_

Medications your child is now taking \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

