Liability/Medical Release

Each swimmer will need a separate form

Liability/Medical Release Form ORIGINAL _____

Print Your Last Name Here

If I am injured while participating in programs with the Alligator Aquatics, my family and I agree to waive any legal claim against USA Swimming, and those associated with USA Swimming, Illinois Swimming Inc. (ISI), Arlington Heights Park District, School District 214, Saint Viator HS, Harper College, Plum Grove Park District, Alligator Aquatics, and each of their respective officers, directors, Board Members, employees, agents and independent contractors. I give consent for the Alligator Aquatics to provide medical/athletic-training attention, transportation and emergency medical services as warranted. If I am injured while traveling to or from the Alligator Aquatics by public, private or any other means of conveyance, I agree to waive any legal claim USA Swimming, Illinois Swimming Inc. (ISI), Arlington Heights Park District, School District 214, Saint Viator HS, Harper College, Plum Grove Park District, Alligator Aquatics, and each of their respective officers, directors, Board Members, employees, agents and independent contractors. By signing this release, I swear that I am in good physical condition and am not aware of any disease or injury that would result in my being injured during any program participation. If I am under 18 years of age my parent or guardian shall sign this release with me.

Print Name of swimmer: _____ Swimmers Gender (M/F) _____

Signature of Swimmer: _____

Signature of Parent/Guardian (If athlete is under the age of 18) _____Date_____

To whom it may concern:
I/We do herewith authorize the treatment by a qualified and licensed medical doctor of the following in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach a guardian (if athlete is under the age of 18). I/We do also attest that the questions answered below are accurate.

Name of athlete: _____ Signature of athlete_____

Signature of Parent/Guardian (If athlete is under the age of 18) _____Date: _____

Please check the appropriate answer. (*All information will be kept confidential*)

Yes No

( ) ( ) Has the athlete ever been hospitalized, or had surgery, a major injury or serious medical illness? (If YES, please specify):

_____

( ) ( ) Is the athlete currently under the care of a physician for a medical problem or currently taking medication? (If YES, please specify):

_____

( ) ( ) Has any physician ever recommended or do you feel that there should be limits placed on participation in competitive sports? (If YES, please specify):

_____

( ) ( ) Does the athlete have any known allergies to medications? (If YES, please specify):

_____

( ) ( ) Has the athlete ever blacked out or lost consciousness during physical activity? (If YES, please specify):

_____

( ) ( ) Does the athlete wear contact lenses?

( ) ( ) This athlete is in good physical condition and has no condition or impairment which would impair participation or endangered their health in a physical training program.

Family Physician: _____Phone: _____

Emergency contact: _____ Phone: _____
Insurance Carrier: _____ Policy #: _____