Rockford Aquatic Club

Medical Release Form

I give permission for medical treatment for my son ______________________________
during these dates: July 19 - July 25, 2018.

Parent Signature ____________________________ Date signed ________

Home phone number ________________________

Work phone number ________________________

Cell phone number _________________________

Other parent phone number ___________________ describe _____________________

Emergency phone number ____________________ relation ______________________

Emergency phone number ____________________ relation ______________________

Please list any medications your child is taking or will have with them:

____

Please list and describe any allergies ____

Please describe any other pertinent medical history ______________________________

____

Date of last tetanus shot _______________________________

Please attach copies of both sides of your insurance card.