Consent for Treatment of a Minor

This is to certify that my son(s)/daughter(s) listed below has my permission to participate in the Westover Wild Orcas Swim Team. As the parent or legal guardian, I request that in my absence, the below named swimmer (s) be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of my minor child. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from my minor child.

Swimmer:	**Allergies (Including to Medication) or Other Medical Conditions:**

Family Doctor or Pediatrician:	
Doctor's Phone:	
Emergency Contact:	
Contact's Phone:	
Insurance Company:	
Policy Holder:	
Policy Number:	

Parent or Guardian Signature:	**Date:**
Parent or Guardian Signature:	**Date:**