Clovis Swim Club
Masters/Triathlon Emergency Form

Athlete's Name:_____
Last First Middle

Athlete's Date of Birth_____ Gender: M, F
mm/dd/yyyy

Athlete's Home Phone:_____ Cell: _____

Medical Information: Please circle all that apply.

Glasses/Contacts Heart Condition Epilepsy/seizure Hearing Difficulty

Asthma Tuberculosis Diabetes Bleeder Allergies

Pre-existing Serious Injury:_____

Medical or Food Allergies: _____

Other:_____

Current Regular Medication:_____
(name of drug, dosage, supervising physician, contact #)

_____

Emergency Contacts:

Name:_____
Home Phone Cell Phone

Name:_____
Home Phone Cell Phone

Physician:_____
Name Phone #

Insurance: _____
Name Phone # Policy #

I hereby sign that the information provided above is accurate. Clovis Swim Club/ CUSD has my permission to use and distribute this information to its facilities and staff as they see fit. In the event of an emergency, Clovis Swim Club/CUSD has my permission to contact any emergency services they see fit. I further understand that any medical costs of treatment provided in relation to this authorization shall be borne by the undersigned.

Athlete's Signature_____ Date: _____