

**Renton Youth Crew: Medical Release and History**

*This form expires on 12/31 of the calendar year in which it was signed*

**Name of Participant:** \_\_\_\_\_

I hereby authorize and consent to the administration of any and all medical, dental, and surgical examinations or operations and treatment or all other related care, including the administration of drugs, tests, anesthesia, and/or blood transfusions to the above named minor person that may be ordered by a physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above named minor person to the hospital.

I understand that the Renton Rowing Center and their officers, employees, and volunteers assume no financial obligation or liability in the case of my child's accident or illness. If I, or anyone on my or my child's behalf makes a claim against the Renton Rowing Center or their officers, employees, and volunteers arising out of or related to my child's participation in Renton Rowing Center programs, I agree to indemnify and save and hold them harmless from any litigation expenses, attorneys' fees, loss, liability, damage, or costs they may incur due to the claim made against any of them, whether the claim is based on their negligence or otherwise. I sign this agreement on my behalf and on behalf of my personal representatives, assigns, heirs, and next-of-kin. I hereby give permission for emergency treatment for my child and assume financial responsibility for such treatment.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Athlete: \_\_\_\_\_

**First person to contact in case of emergency:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Alternate person to contact in case of emergency:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Address: \_\_\_\_\_

**Health Insurance:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Asthma (circle):** YES NO      **Does this child carry an inhaler? (circle):** YES NO

**Other Medical Concerns (allergies, activity limitations, etc. Please be specific):**

\_\_\_\_\_