

**AUTHORIZATION TO TREAT A MINOR  
WHILE TRAVELING WITH CHAWP WATER POLO CLUB  
March 30 through April 9, 2017**

My child, \_\_\_\_\_, is a member of CHAWP Water Polo Club and has my permission to participate in all activities including but not limited to practices, scrimmages, games, tournaments while traveling in Europe. I certify that my child has full medical insurance. I also certify, to the best of my knowledge, that my child is physically fit and able to participate in sporting events.

I acknowledge that water polo is an extreme sport and can lead to minor or serious bodily injury. With full understanding of the potential risks, I hereby assume those risks of participation. In the event of an injury, I assume financial responsibility for the bills incurred.

In the event of injury or sudden illness, I as legal guardian, hereby grant my permission for my child to be treated by a qualified and licensed physician in the event that immediate treatment is necessary, as determined by the attending physician. Permission for treatment is authorized in the event that I am unable to be reached following a reasonable effort to do so. I understand that it is my responsibility to inform the club administration when my contact information changes.

Parent/Guardian's Printed Name \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_



**PLEASE COMPLETE:**

Athlete's Name \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Cell ( ) \_\_\_\_\_ Father's Cell ( ) \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_ Additional Phone ( ) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Group # \_\_\_\_\_

Phone ( ) \_\_\_\_\_

List all medications/dose/frequency taken:

\_\_\_\_\_

\_\_\_\_\_

Allergies and/or other medical conditions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_