VASHON SEALS SWIM TEAM
PO BOX 1824, VASHON WA 98070
WWW.SWIMVASHON.ORG
SEALS@SWIMVASHON.ORG

CONFIDENTIAL MEDICAL RELEASE FORM

Swimmer Last Name:	Date of Birth:
Swimmer First Name:	Age:
Physical Address:	

Primary Emergency Contact	Secondary Emergency Contact
Name:	Name:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Physical Address:	Physical Address:

While the VSST will make every effort to contact the swimmer's parent in the event of an emergency, the following release is necessary:

I, _____, the parent or legal guardian of _____ do hereby give permission for my child to participate in the VSST activities, including swim meets. In the event that my child is injured or should require medical attention, I authorize the VSST to contact the physician listed below. If necessary, I further authorize a VSST representative to secure necessary medical treatment for my child while participating in swim team activities. I further acknowledge that I will be responsible for any resulting medical or hospital fees or costs associated with my child's medical treatment, including transportation costs. I realize that the obtaining of emergency medical treatment by VSST in no way renders VSST liable for the expense of obtaining such treatment. I release and hold harmless the VSST and its coaches, officers and other representatives from any and all liability for any injury that may occur to my child while participating in any approved swim team activity.

Parent's/Guardian's Signature: Date:

Medical Information	
Doctor:	Phone:
Insurance Company:	Policy/Group#:
Special instructions regarding emergencies or chronic conditions:	