IOWA DIVING CLUB MEDICAL RELEASE FORM

(All information will be confidential.)

bradjvirkler@gmail.com - 319.321.9434

NAME_____BIRTHDATE____/____/____AGE_____HEIGHT_____WEIGHT_____

ADDRESS_____
Street city state zip

EMAIL_____

IN CASE OF EMERGENCY:

PARENT(S) NAMES_____HOME PHONE_____CELL PHONE _____

PARENT(S) EMPLOYER (MR)_____(MS)_____

WORK PHONE(MR)_____(MS)_____EMAIL_____

FAMILY PHYSICIAN_____PHONE_____

MEDICAL INSURANCE CARRIER_____POLICY #_____

Does the above athlete wear glasses? YES_____ NO_____ Wear contact lenses? YES___ NO____
Severe visual impairment without correction? YES___ NO____
Allergic to any medications or substances? YES___ NO____
If yes, please list_____
History of shoulder, back or knee injury? YES___ NO____
If yes, please describe_____
History of ear infection? YES___ NO____
If yes, please describe_____
History of seizures? YES___ NO____
If yes, please describe_____
Take any medication? YES___ NO____
If yes, please list_____
Any other medical problems or conditions? YES___ NO____
If yes, please describe_____
Are there any physical limitations that may hinder the divers participation in the program? If yes, please describe _____
_____
Is the diver current on all required immunizations? YES___ NO____

I (we), the undersigned parent(s) or legal guardian(s) of_____, a minor, do hereby authorize IOWA DIVING CLUB as agent for the undersigned to obtain medical treatment for the above child and to consent to x-ray examination. Anesthetic, medical or surgical diagnosis of treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of a licensed physical and/or surgeon under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospitalization care being required but is given to provide authority and power on the part of our aforesaid agent to specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgment, deems advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient but that any of the above treatment will not be withheld if the undersigned cannot be reached.

It is further understood that I/we the undersigned are responsible for all charges for the above-mentioned diagnosis, treatment, or hospital care.

I CERTIFY THAT THE ABOVE NAMED DIVER IS MEDICALLY AND PHYSICALLY ABLE TO PARTICIPATE IN THE IOWA DIVING CLUB. I ACCEPT THE RESPONSIBILITY TO INFORM THE IOWA DIVING CLUB OF ANY FUTURE CHANGE(S) OF THE ABOVE INFORMATION.

_____ _____ _____
Athlete (signature) Athlete (printed name) date

_____ _____ _____
Parent or Legal Guardian (signature) Parent or Legal Guardian (printed name) date