

Del Mar Water Polo Club

Player Emergency Information

Player's Name: _____ Birthdate: _____ M or F

Parent/ Guardian: _____ Phone (C) _____ (H) _____

Parent/ Guardian: _____ Phone (C) _____ (H) _____

Alternate Contact: _____ Phone (C) _____ (H) _____

Family Health Insurance Company: _____

Policy Number: _____

Primary Physician & Phone #: _____

Emergency Information: Including Allergies (Medicines, Food, Bee Stings etc.), Please also provide specific instructions regarding current medical conditions being treated and medications currently used.

EMERGENCY MEDICAL AUTHORIZATION: (Agent: Authorized Agent of Del Mar Water Polo Club)

I/We, parent(s)/person(s) having legal custody/legal guardian of a minor, do hereby authorize medical, dental or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician, dentist or at said hospital. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority to the aforesaid Agent to give specific consent to any; and all such diagnosis, treatment, or hospital care which a physician or dentist meeting the requirements of this authorization may in the exercise of his/her best judgment deem advisable.

This authorization is given pursuant to the provisions of Sections 6910 and 6550 of the Family Code of California.

This authorization shall remain effective while your minor is registered and playing with the Del Mar Water Polo Club unless revoked in writing and delivered to said agent(s)

Dated: _____

Dated: _____

Print: _____

Print: _____

Parent/ Guardian

Parent/ Guardian

Sign: _____

Sign: _____

Parent/ Guardian

Parent/ Guardian