

MEDICAL RELEASE

Grade _____

In the event that my dependent (swimmer's name) _____, is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision or while participating in any activities sponsored by HEIDELBERG SEA LIONS, CMR 419 BOX 1644, APO AE 09102, I authorize and release to any agent or employee of HEIDELBERG SEA LIONS to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of Heidelberg Sea Lions will use all diligent and reasonable efforts to contact my spouse or me. If neither my spouse nor I can be contacted after reasonable attempts by personnel of Heidelberg Sea Lions or the U.S. treatment facility, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger of life or limb of my dependent. I further authorize non-emergency care necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT *(to be completed by the parent and shared with team personnel and health care providers on a "need to know" basis)*

➤ My dependent has the following medical problems (such as diabetes, seizures, asthma, ADHD, heart problems, kidney disease, etc.): _____

➤ My dependent has had the Chicken Pox? _____ YES (____/____) _____ NO (____/____)
Mo/Yr Date of Chicken Pox vaccine Mo/Yr

➤ My dependent is allergic to the following: _____

➤ My dependent takes the following medications on a regular and/or "as needed" basis *(list name and amount of each medication)*: _____

SPONSOR CONTACT INFORMATION *(to be completed at registration and updated as needed by the parent)*

Home Address _____ Home Phone # _____

Sponsor's Name _____ Rank _____ Cell Phone _____

Sponsor's Unit _____ Work Phone # _____

Spouse's Work Phone _____ (include prefix) Spouse's Cell Phone # _____

Other Names and Phone Numbers to Use in Case of Emergency if Parents are Unavailable:

Additional Comments: _____

I AGREE TO NOTIFY THE TEAM IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Date _____ Signature of Parent/Guardian _____

Sponsor's Social Security Number _____

Are you a Civilian "Pay Patient"? _____ Yes _____ No

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) to obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. Health Data collected will be entered into the school health computer program for use by health and educational personnel on a need to know basis. This form is used by DoDDS employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory. School Personnel will not be able to provide emergency care and health in parents' absence.