## Cleveland Area Diving

## 2019-20 EMERGENCY INFORMATION

Age Group, Senior, and Master Springboard and Platform Diving Program

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| Diver's Name  |   |
|---|---|
| Address   |   |
| City, State & Zip   |   |
| Birth Date  |   |
|   | Cell Phone  |
|   | Cell Phone  |
|   | _ Cell Phone  |
| Primary Email Address for communication   |   |
|   | parent during the day because of accident or illness. |
| Name  | Relationship  |
| Place of work   |   |
|   | Cell Phone  |
| In an emergency, when it is impossible to contact you, do you authorize a CLEVELAND AREA DIVING representative to take your child to the hospital? Yes No |   |
| Physician's Name  | Phone   |
| Dentist's Name  | Phone   |
| In the event reasonable attempts to contact me at   | (phone)   |
| or  | (Name of other parent or guardian)                    |
| at(ph   | none) have been unsuccessful,                         |

| I hereby grant consent for the administration | of any treatment deemed necessary by  |
|---|---|
| Dr  | (preferred dentist) or  |
| Dr  | (preferred physician);  |
| and the transfer of the child to              | (preferred hospital)  |
| or any hospital reasonably accessible.        |   |
|   | ery unless the medical opinions of two other licensed ssity for such surgery, are obtained prior to the performance |
| Date of Last Tetanus Shot                     |   |
| Signature of Parent or Guardian               |   |
| Signature of Notary (Travel team only)        | Present Date  |
| Hospitalization Insurance Company             |   |
| Policy Number                                 |   |
| •   | ncluding allergies, medications being taken, and any  |
| impairments to winch a physician should be a  | lerteu.   |
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