



Cascade Rhythmic

Medical Release Form

This must be completed and signed in all areas by both athlete and parents. I understand and agree that this document will be kept in the possession of authorized personnel and that reasonable care will be used to keep this information confidential. By signing this form the participant affirms having read and agreed to terms and conditions listed below:

Gymnast Name _____ D.O.B. _____ Age _____

Gymnast Name _____ D.O.B. _____ Age _____

Primary contact parent name _____ Phone number _____

Secondary contact name _____ Phone number _____

Primary Insurance Co. _____ Group/Policy # _____

Family Physician Name _____ Physician Phone # _____

Please elaborate on any medical conditions of which we should be aware: _____

Please list any medications currently being taken: _____

Please list any allergies: _____

In the event of an emergency or non-emergency situation in which my child requires medical attention at Cascade Rhythmic I hereby grant permission to the owner, faculty or agents of Cascade Rhythmic, for any and all medical and/or dental attention to be administered to my child, at my expense in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but does not limit to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of a qualified personnel. I will assume financial responsibility for the bills incurred through my insurance company and my expenses.

Parent Signature _____ Date _____

Or

I do not authorize emergency medical care for my child.

Parent Signature _____ Date _____