



C.I.R. Medical Authorization
1/1/2021 - 12/31/2021

Participant: _____
Last First Middle I.

Address: _____
Street, City State Zip

Medical illnesses, allergies or limitations my child has regarding active participation in the C.I.R. rowing program that I /we believe the coaches should be aware of and monitor:

Medications:

Primary Doctor : _____ Phone _____

Authority to act:

During my child's participation in City Island Rowing activities, I / we authorize the coaches of this program to make decisions and to proceed with any critical medical or surgical treatments required for my child's health and welfare, provided every reasonable attempt was made to contact us, the parents, first. In the event that we the parents or guardians cannot be reached, I / We give City Island Rowing permission to seek medical attention for said child.

Signature: _____
Parent/ Guardian Date

Name Phone #

Signature: _____
Parent/ Guardian Date

Name Phone #

In Case of Emergency Call First: _____

Additional emergency contact:

Full Name and Contact # _____

Relation to participant _____

Medical Insurance Company: _____

Plan: _____ Membership # _____

(Please insert photo of / photocopy the card below or reverse, thank you.)