

## Cazenovia Rowing Club - Medical Information Sheet

*Note: No rower will be allowed to practice or race with the team unless this form is returned to the rower's coach or to CRC PO Box 533, Cazenovia, NY 13035.*

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Birthdate (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home Phone (if other than above): \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone (if other than above): \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_

Emergency Contact (other than parents): \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

\_\_\_\_\_

Please give the date of your last immunization for Tetanus \_\_\_\_\_

Are you up-to-date on all other immunizations as required by New York State Department of Education athletic policies. Yes \_\_\_\_\_ No \_\_\_\_\_

Is there anything medically we should know about? Please be specific.

*Please read the authorization on Page 2, sign and return to the rower's coach.  
Thank you.*

**AUTHORIZATION FOR THIRD PARTY**  
(To consent to treatment of minor lacking capacity to consent)

I/we, the undersigned, parent(s)/person having legal custody of/legal guardian of \_\_\_\_\_ a minor, do hereby authorize the Cazenovia Rowing Club as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required by is given to provide authority to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment deem advisable.

I/we hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to my/our above named agent(s) upon completion of treatment.

These authorizations shall remain effective until December 31st of the current year unless sooner revoked in writing delivered to said agent(s).

Signature of parent(s)/legal guardian(s)/person(s) having legal custody

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

If signed by other than parent, please indicate relationship. \_\_\_\_\_

**Send completed forms to:**

Cazenovia Rowing Club, PO Box 533, Cazenovia NY, 13035