EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Braves Rowing, Inc.

Athlete's Legal Name:______________________________ Grade:______________

Athlete's Date of Birth:______________________________ Date of last tetanus shot:________

My child is allergic to the following medications:______________________________

My child has the following allergies:______________________________

Please identify any serious injuries or illnesses your child has had:______________________________

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In case of emergency, contact: ______________________________ (print name and relationship to athlete)

Phone:______________

Alternate family member/friend to contact in case of emergency:

Name:______________________________ Phone:______________

Primary Care Doctor Name:______________________________ Phone:______________

Primary Insurance Company:______________________________ Policy #:______________

Insurance Company Address: ______________________________

(*All participants may be required to have insurance per OCPS Policy. Participants will be notified if insurance and proof of insurance is required. Write "none" if you have no personal insurance on this athlete at this time.*)

I understand if anyone falsifies any signature or information on this emergency treatment authorization, the student will be declared ineligible to participate in any BRAVES ROWING, INC. d/b/a Boone Crew ("BRI") activity (which includes, without limitation, participation in the Jr. Braves rowing program) for one full calendar year from disclosure date. I further give permission and authorize the officers, board members, program directors, coaches, school staff or other representatives of BRI, as agent(s) for the undersigned, to consent to any x-ray examination, and the anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under 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 said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or agent(s) to give specific consent to any and all such diagnoses, treatment or hospital care which the physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. I further agree to hold said agents and their respective employees harmless in the administration of such assistance. I hereby authorize any hospital which provided treatment to the above named minor to surrender physical custody of such minor to my above named agent(s) upon completion of treatment. These authorizations will remain in effect for one (1) year from the date hereof unless revoked in writing and delivered to said agent(s).

I hereby acknowledge and certify that I have read the emergency medical treatment document, that I understand and agree with its terms, and that I make the following written declaration under Section 92.525, Florida Statutes: "Under penalties of perjury, I declare that I have read the foregoing Emergency Medical Treatment Authorization and that the facts stated in it are true." I agree to be bound by its terms and I have reviewed and explained the notice with my child.

I understand, authorize, and consent to the release of my child's or ward's protected health information to my child's or ward's coach, assistant coach, and to any adult chaperone who is transporting my child or ward or who is assigned to oversee my child or ward at any BRI event or trip of any kind on a strictly limited and need to know basis to protect the health and safety of my child or ward and the other student rowers who participate in BRI's rowing programs.

Printed Name of Participant:______________________________

Signature:______________________________ Date:______________

Permanent Address:______________________________

(Number/Street) (City) (State) (Zip Code)

If Participant is under 18, parent/guardian signature is required below.

Printed Name of Parent/Legal Guardian:______________________________

Signature:______________________________ Date:______________

Relationship:______________________________ Phone:______________