Y of Central Maryland
It's deeper here.®

Summer Sports & Swim Clinic - Emergency Information

Participants Name _____ Date of Birth _____ Age _____

Participants Address _____ City _____ State _____ Zip _____ Phone _____

Emergency Contacts- THREE CONTACTS ARE REQUIRED

(Please list people that should be contacted in the event of a medical emergency)

Contact Name #1_____Relationship_____Phone_____

Contact Name #2_____Relationship_____Phone_____

Contact Name #3_____Relationship_____Phone_____

If your child has ANY special needs that will affect his/her behavior or participation in clinics PLEASE list them below so the sports staff may best serve your family. Does your child now or at any time in the past: (circle all that apply)

Wear Glasses	Have an illness	Behavioral Problems
Wear Contacts	Have a limiting Condition	ADD/ADHA on Meds.
Wear Hearing Aid	Take prescription Medication	ADD/ADHA off Meds
Have allergies	Taking over the counter medication	

Please Explain:_____

_____

_____

_____

If your child has to bring medication to the clinic **YOU MUST FILL OUT THE MEDICAL FORM. (i.e. inhaler)

PICK UP AUTHORIZATION

The following people are authorized to pick up my child from the Y of Central Maryland Summer Sports Clinics. Any person not on the list below will be unable to escort your child from the Y of Central Maryland property. **A photo ID must be presented at the time of pick up.**

Adult/Guardian
#1_____Relationship_____Phone_____

Adult/Guardian
#2_____Relationship_____Phone_____

Adult/Guardian
#3_____Relationship_____Phone_____

Authorization for Emergency Medical Treatment

If my child should become ill or injured during Y of Central Maryland activities, I understand that the Y will: 1) contact me immediately; 2)contact the person(s) I have designated in case I cannot be reached. Should the Y of Central Maryland be unable to reach me or the person(s) designated, the Y is authorized to arrange for immediate medical treatment to ensure the health and safety of my child, including the administration of medications of injections provided by me for such purpose. I accept responsibility for payment of medical services rendered.

Parent Guardian Signature_____
Date_____ Updated 01/2013