

City of Albuquerque Parental Permission, Medical Release and Waiver Form

Permission: For _____ (participant's name). I hereby give the City of Albuquerque permission for myself to participate in the SwimLab program. I acknowledge that some of the activities of the program may be off City property and give my permission for to participate in such activities.

Medical Release: I authorize the City staff to act on my behalf if medical treatment for myself is necessary. In the event of illness or injury to myself, I authorize the City to obtain medical treatment for myself and authorize medical services to be provided under the medical insurance identified below, or if none, at my own expense.

Liability Waiver: I agree to hold the City harmless for any injury or medical or other health care problem I may incur during participation on the program, both on and off City property. I agree to pay all medical costs related to any injury or illness that I may incur during participation in the program. I further agree that the City shall not be responsible for payment of medical services for myself and acknowledge and agree that any City insurance that may exist does not cover my medical costs unless I am an employee that is already covered by the City of Albuquerque.

Medical Information: Medical insurance that provides health care coverage for myself is listed below. The following is a list of all medical problems, allergies, medications being taken and restrictions due to my health conditions:

I may not take the following medications: _____

The name of my physician is: _____

Day phone _____ Night phone _____

Preferred Hospital _____

Responsible Party: Identify who is the responsibility party for payment of health care for the participant. List yourself as the provider if there is no medical insurance coverage.

Responsible Party/Insurance Provider : _____

Phone: _____

Medical Care Contacts: List two people that the City may contact in the event the child requests medical care or the City determines that the child is in need of medical care.

Name of contact: _____ Home Phone: _____

Relationship to participant: _____ Work or Cell Phone: _____

Name of contact: _____ Home Phone: _____

Relationship to Child: _____

Work or Cell Phone: _____

Authorize to Release Child: In the event I requires medical care, as determined by the City or requested by myself, I authorize the City to release my child to the custody of any one of the people named above as Medical Care contacts.

Parent/Guardian signature: _____ Date: _____

Printed name of Parent/Guardian: _____

Witnessed by City Staff: _____ Date: _____