C.I.R. Medical Authorization
1/1/2025 - 12/31/2025

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 / chaperones 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 add photo of / photocopy the card below or reverse, thank you.)