Golden West Water Polo Club
AUTHORIZATION & CONSENT TO TREAT MINOR and RELEASE

Minor's Full Name: ____
(Last) (First) (MI)

Date of Birth: ______________________________
(Month) (Day) (Year)

The undersigned parent or guardian of, a minor does hereby give consent to any emergency x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to render under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of The coaches of Golden West Water Polo Club(agent) and the "Persons to contact in an emergency" to give specific consent to any and all such diagnoses, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action.

A fax or other electronic copy of this Authorization and consent is as valid as the original. This authorization is given pursuant to the provisions of Section 6910 of the Family Code of California. I realize that the sport of water polo is potentially dangerous and involves considerable risk including the possibility of broken bones, other internal injuries, or death. Therefore, I do hereby for myself, my heirs, executors, and Administrators release any coach of the Golden West Water Polo Club, USA Water Polo, Inc., and the owners of the pool facilities where practices, games or tournaments are played from all claims, demands, actions, liability or causes of actions resulting from any injury or death to me, my son or daughter, my ward, or my property which may occur during participation in this club sport.

Family Doctor and/or Associate:

____
(Physician's Name) (City) (Phone)

Please indicate ANY Medical Problems, Conditions or Allergies (write none if none):

____

Medical Insurance Company:

____
(Name) (Policy Number) (Phone)

Person(s) to contact in an emergency:

____
(Name) (Phone) (Relationship)

____
(Name) (Phone) (Relationship)

This authorization shall remain in effect for the 2008 calendar year or until revoked in writing from the Parent or Legal Guardian:

____
(Print Name)

____
(Signature) (Date)

____
(Address) (City) (State) (Zip)

(Phone) ________________________________ (Alternate Phone)________________________________