Authorization for Emergency Medical Treatment Form

Name:_____ DOB:_____

Home #:_____Work #: _____ Cell#: _____

Email : _____

Physician's Name: _____ Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to medication:

_____

In the event of an emergency, contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the class, or while in the gym, I authorize Champions Academy to:

1. Secure and retain medical treatment and transportation if needed
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan
This authorization includes x-ray, surgery, hospitalization; medication or any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Parent or Legal Guardian

Non-Consent Plan
I DO NOT give my consent for emergency medical treatment/aid in the case of illness or injury during the class, or while in the gym. In the event of an emergency treatment/aid is required, I wish the following procedure to take place:

_____

Date: _____ Consent Signature: _____
Parent or Legal Guardian

Participant's Medical History & Physician's Statement

Participant: _____ DOB:_____ Height:_____ Weight:_____

Diagnosis: _____ Date of onset:_____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation: Y N Wheelchair: Y N

For those with Down Syndrome: AtlantoDens Interval x-rays, date: _____ Result + -

Neurological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Physician's Signature: _____ Date: _____

Please print, type, or stamp
Physician's Name: _____

Address: _____ Phone: _____

Participant Name: _____DOB: _____

Please describe the participant's abilities/difficulties in the following areas (including assistance required or equipment needed):

Function (i.e., mobility skills such as transfers, walking, wheelchair use)

_____

_____

Social/Behavioral (i.e., school, interests, companion animals, fears/concerns, etc.)

_____

_____

Goals (i.e., why are you applying for participation? What would you like to accomplish?)

_____

_____

Physician's Statement

To my knowledge, there is no reason why this person cannot participate in supervised gymnastics activities. I am aware that there are some strenuous activities involved in gymnastics and I am comfortable with this child participating in the following:

Please check:

____ vault ____bars ____ balance beam ____air trak (inflatable 40 ft. track)

___ Rolling (log) ____ rolling (forward roll over their head) ____ turning upside down

____swinging on the bars _____ jumping ____ jumping off of things

____ standing on their head _____ standing on their hands _____climbing

_____ Inversions (such as backbends)