Norwalk River Rowing Association

One Moody's Lane • Norwalk, CT 06851 • Phone: 203 866 0080 • FAX: 203 299 1672 • Email: info@norwalkriverrowing.org

Emergency Card / Sport Medical Authorization / Parent's Form

Athlete's Last Name:	**First**	
Insurance Company	**Group #**	
Certificate #	**Insurance Type**	
Employer of Policy Holder	**Policy Holder**	**Policy Holder ID**
Doctor's Name (1st choice)	**City**	**Dr's Phone**
Doctor's Name (2nd choice)	**City**	**Dr's Phone**
Dentist	**City**	**Dentist Phone**
In case of emergency, call first:	**City**	**Phone**
Emergency Contact (in case parent can't be reached)	**Emergency Contact Telephone #**	

To be completed by parent (Health history)

TO BE COMPLETED BY PARENT Please check off accordingly (health history)

Asthma: **Inhaler: □ YES □ NO** **□Diabetes Rx:** **□Seizures Rx:** **□Cardiac Issues:** **□Fainting/dizzy spells:** **□EPI-Pen □YES □NO**	**Family History: (e.g. heart attacks, seizures, death under 50 etc.)** **Significant allergic reactions: Rx**

Significant injury in the last 12 months (e.g. concussions, fractures etc.):

Other significant medical history:

I verify this information is complete and accurate.

Signature _____ **Date:** _____

Please return completed forms to:
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1 Moodys Lane, Norwalk, CT 06851

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Sports Medical Authorization-Physician's Form

Valid for ONE YEAR only from date of examination.
To be completed by physician.

HT	WT	BP	Vision

Contacts: □ Normal □ Abnormal	**Hearing:** □ Normal □ Abnormal
Skin: □ Normal □ Abnormal	**Musculoskeletal:** □ Normal □ Abnormal
Head: □ Normal □ Abnormal	**Spine/Scoliosis:** □ Normal □ Abnormal
Eyes: □ Normal □ Abnormal	**Neck:** □ Normal □ Abnormal
Eyes, Nose, Throat: □ Normal □ Abnormal	**Shoulders:** □ Normal □ Abnormal
Heart: □ Normal □ Abnormal	**Hand/arms:** □ Normal □ Abnormal
Lungs: □ Normal □ Abnormal	**Hips:** □ Normal □ Abnormal
Abdomen: □ Normal □ Abnormal	**Knees:** □ Normal □ Abnormal
Genitalia: □ Normal □ Abnormal	**Ankles:** □ Normal □ Abnormal
Neuro: □ Normal □ Abnormal	**Feet:** □ Normal □ Abnormal

Comments:

I certify that _____ is able to participate in interscholastic sports as of _____ (date of exam).

Physician's Signature:

Physician's Name (Please print legibly):

Address:	Phone:

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