

# City of Albuquerque Parental Permission, Medical Release and Waiver Form

**Parental Permission:** For \_\_\_\_\_ (participant's name). I hereby give the City of Albuquerque permission for my child to participate in the Learn to Swim program or the Swimming/Water polo program. I acknowledge that some of the activities of either program may be off City property and give my permission for my child to participate in such activities.

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

**Liability Waiver:** I agree to hold the City harmless for any injury or medical or other health care problem my child may incur during participation on the program, both on and off City property. I agree to pay all medical cost related to any injury or illness that my child may incur during participation in the program. I further agree that the City shall not be responsible for payment of medical services for my child and acknowledge and agree that any City insurance that may exist does not cover my child's medical costs.

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

My child may not take the following medications: \_\_\_\_\_

The name of my child's physician is: \_\_\_\_\_  
Day phone \_\_\_\_\_ Night phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

**Responsible Party:** Identify who is the responsibility party for payment of health care for the child. List yourself as the provider if there is no medical insurance coverage.  
Responsible Party: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Work or Cell 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 Child: \_\_\_\_\_ Work or Cell Phone: \_\_\_\_\_  
Name of contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Work or Cell Phone: \_\_\_\_\_

**Authorize to Release Child:** In the event my child requires medical care, as determined by the City or requested by the child, 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: \_\_\_\_\_