



C.I.R. Medical Authorization  
1/1/2026 - 12/31/2026

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.)