ATLANTIC DIVING TEAM
WWW.ATLANTICDIVINGTEAM.COM

# Participant Waiver & Emergency Medical Form

Diver's Name_____ Birth date_____

Class/Program Level_____ Date_____

Street Address_____ Phone # (H)_____

City, State, Zip_____ Phone #(W)_____

E-mail _____ Phone #(cell)_____

Occupation (Dad)_____ (Mom)_____

The Atlantic Diving Team offers some classes and programs on a limited basis. There are certain risks inherent in the use of equipment and/or participation in certain programs that you should consider before you begin such activities.

As a participant in these classes and programs, the undersigned on behalf of our minor dependents and ourselves (collectively, "our") understand that participation can involve physical activity, which could result in injury. The undersigned also understands that use of the facilities is exclusively limited to the area(s) in which the class or program is being conducted and that use will be strictly under staff supervision.

For, and in consideration of, the Atlantic Diving Team these programs, and Martin County allowing use of its facilities for this program, and with the understanding of the risks involved in our participation, the undersigned on behalf of ourselves, our dependents and heirs agree to release and forever discharge the Atlantic Diving Team and the Martin County, their officers, directors, employees, contractors and agents from any and all liabilities, demands or claims for loss or damage resulting from an injury or damage which may be sustained on account of our participation in these classes or programs, or use of the facilities.

Print_____ Signature:_____ Date: _____
Diver's Name or Parent's Name (if minor) Diver or Parent (if minor)

# Emergency Medical Form

I the undersigned/or parent, or legal guardian _____ of ("Participant"), do hereby authorize and consent to Atlantic Diving Team ("Authorized Party"), obtaining for the Participant any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital or emergency room care facility ("Medical Facility") care to be rendered to the participant under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Florida Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or Medical Facility care being required and, except as expressly limited below, is given to provide authority and power to render care which a Physician and Surgeon or Dentist in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned by telephone at the numbers listed below prior to rendering treatment to the participant, but that any of the above treatment will not be withheld if the undersigned cannot be reached. If the Authorized Party is a corporation this authorization shall include any officer, director or employee of said corporation or its affiliates. It is further understood that I (we) the undersigned are responsible for all charges for the abovementioned diagnosis, treatment or hospital care.

**This authorization is given pursuant to Section 743.0645, Florida Statutes.**

Limitations (if any):_____

Date:_____ Signature:_____

THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL:_____

MEDICAL INFORMATION: Birth date_____ Last Tetanus Toxoid Booster_____

CONTACT PHONE #: Print Father's Name_____ Phone (_____)_____

Print Mother's Name_____ Phone (_____)_____

Physician OR Christian Practitioner:_____ Phone:(____ )_____

Known Allergies to drugs or foods: _____

Insurance Co: _____ Policy Number: _____