



_____ (Diver's Last Name)

DIVE Cincinnati, Inc.
Authorization to Consent to Medical Treatment
For An Adult (Diver) During the 2017-2018 Season

(THIS FORM MUST BE NOTARIZED)

I _____ the undersigned confirm that I am at least eighteen (18) years of age at the time of my signing of this form and I myself authorize and grant permission to *DIVE Cincinnati, Inc., one of its coaches or representatives* to consent to any examination, anesthetic, X-ray, medical or surgical diagnosis or treatment and/or hospital care to be rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice when efforts to contact any member of my immediate family are unsuccessful.

This consent is granted for a **period of one (1) year from date listed on form.**

_____ Date ____ / ____ / ____
(Signature of Diver)

(Witness signature)

Notary

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day _____ 20_____

(Notary signature)

My commission expires _____ 20_____

**** NOTE: This signed and notarized Authorization to Consent to Medical Treatment Form and the Emergency Information Form will be kept at the NKU Pool and / or taken to diving meets, Bubbler Trips, etc. in the event that an accident occurs and the parent(s) or guardian(s) cannot be reached. These forms must be fully and properly completed and on file with DIVE Cincinnati, Inc. prior to any participation in the DIVE Cincinnati Program.**