SNOWY RANGE SKI CLUB
CONSENT TO EMERGENCY CARE AND RELEASE
(**Please Print Clearly**)

Name of Participant _____

E-Mail Address: _____

MAILING ADDRESS_____

PRIMARY PHONE_____ AGE____ M/F____ BIRTHDATE_____

PARENT/GUARDIAN NAME: _____

Primary: _____

E-Mail Address: _____

Work Phone_____ Cell Phone _____Home Phone _____

Secondary: _____

E-Mail Address: _____

Work Phone_____ Cell Phone _____Home Phone_____

Parent/Guardian/Participant warrants and represents that Participant is in good health and that any special problems associated with the care of the Participant have been listed on this form. Parent/Guardian hereby authorizes all coaches and representatives of Snowy Range Race Team to call for medical care for the Participant or to transport Participant to a medical facility or hospital, if in the opinion of such personnel medical attention is necessary. Parent/Guardian also consents to the care, treatment and/or procedures given under the instructions and directions of a licenses physician. It is understood that every effort will be made to notify Parent/Guardian at the earliest possible time in the event such care/treatment is undertaken. Parent/Guardian knowingly and voluntarily consents in advance to such care, treatment and/or procedures to encourage Snowy Range Race Team coaches and representatives to exercise their best judgment in undertaking such care, treatment and/or procedures. Parent/Guardian agrees to pay all costs associated with such medical care and related transportation and shall specifically agree to defend, indemnify, and hold harmless all Snowy Range Race Team coaches and representatives from any and all costs arising out of such care, treatment, and/or procedures.

Participant's Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

OTHER EMERGENCY CONTACTS:
Person other than Parent/Guardian: _____Phone: _____
Family Physician: _____Phone: _____
Family Dentist: _____Phone: _____
MEDICAL Conditions (Y/N), IF YES PLEASE EXPLAIN _____
_____
KNOWN ALLERGIES: _____
PRESCRIPTION MEDICATIONS TAKEN BY PARTICIPANT: _____
_____
PARTICIPANTS ARE REQUIRED TO HAVE THEIR OWN HEALTH OR ACCIDENT INSURANGE:
Insurance Company: _____Phone: _____
Insurance Company Address: _____
Policy Number: _____Group Number: _____
Person Insured: _____Relationship to Participant _____