

Eastern Ski Jumping & Nordic Combined

RELEASE AUTHORIZATION FOR MEDICAL ATTENTION

Athlete 1: _____ Date of Birth: _____

Athlete 2: _____ Date of Birth: _____

Regular Doctor: _____ Phone: _____

Health Insurance Plan: _____

Member ID & Group #: _____

Telephone: _____ Subscriber: _____

Parents/Guardian: _____

Mailing Address: _____

Telephone Home: _____

Work: _____

Cell: _____

Is there a neighbor or relative to contact if you cannot be reached?

Name: _____

Telephone: _____

I hereby authorize any first aid, medication, medical treatment, hospitalization or surgery deemed necessary in case of emergency. I also authorize the attending coach(es), team leader(s), or assistants to execute on my behalf any permission forms and other appropriate medical documents on my behalf if I am not immediately available to do so. I understand that I am responsible for any charges incurred for medical treatment and I am also aware that payment may be due at the time of service.

X _____
Parent/Guardian's Signature Date

PLEASE list any known allergies, medical conditions or medications for each child:

PLEASE ATTACH a COPY of the FRONT & BACK of the INSURANCE CARD