

Brockport Ski and Snowboard Club
Student Information/Medical Authorization Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone with Contact Name: _____

Cell Phone with Contact Name: _____

E-Mail : _____

Grade: _____ Team/Homebase Teacher/Advisement Teacher: _____

Circle One: **Skier** or **Snowboarder** Years Skiing/Snowboarding: _____

Ability Level: **First Timer** or **Green** or **Green-Blue** or **Blue** or **Blue-Black**

The following information will be kept confidential and on-file with the Brockport Ski/Snowboard Club advisors.

****Optional: attach a copy of your/your child's health insurance card to this form.**

Birth Date: _____ Blood Type (if known): _____

Insurance Provider and #: _____

Family Physician: _____ Physician's Phone Number: _____

Special Instructions (drug/other allergies, contact lenses, epilepsy, diabetes, heart trouble, asthma, etc.):

Immunizations up to date: Yes _____ No _____ Date of last tetanus shot (if known): _____

In case of emergency, please notify: _____

If no one answers at the above number, then please notify: _____

This authorizes a licensed physician, surgeon, or other recognized hospital staff member to carry out emergency medical care deemed necessary for my child/ward in an emergency when normal permission is unavailable.

Parent/Guardian

Parent/Guardian