

# Medical Information and Release

(Page 1 of 2)

Participant's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Weight \_\_\_\_\_ lbs. Age \_\_\_\_\_ Sex \_\_\_\_\_

PERSON TO CONTACT IN AN EMERGENCY \_\_\_\_\_ Phone \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

IF YOU NOW HAVE OR EVER HAD ANY OF THE FOLLOWING, PLEASE CHECK:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Ankle/foot injury | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Rheumatism    |
| <input type="checkbox"/> Hernia           | <input type="checkbox"/> Muscle Disorder   | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Head injury       | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Dislocations     | <input type="checkbox"/> Fractures         | <input type="checkbox"/> Back injury   |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Contacts         | <input type="checkbox"/> Heat Exhaustion   | <input type="checkbox"/> Hearing loss  |

EXPLAIN IN FULL ANY ITEM(S) CHECKED ABOVE: \_\_\_\_\_

\_\_\_\_\_

LIST ALL ALLERGIES TO FOOD OR MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

LIST ALL CURRENT MEDICATIONS: \_\_\_\_\_

WHAT IS THE DATE OF YOUR LAST TETANUS BOOSTER? \_\_\_\_\_

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
date

\_\_\_\_\_  
Signature of Parent/Guardian (If Skater is Under 18)

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(Page 2 of 2)

### CONSENT FOR TREATMENT ON ADMISSION TO ANY PHYSICIAN, AND/OR HOSPITAL

I, (Participant or Parent/Guardian if participant is a minor), \_\_\_\_\_  
\_\_\_\_\_ am aware that an injury to the above named participant may occur during skating or hockey classes. Realizing that such injury may require immediate attention, emergency medical and/or surgical treatment, we do hereby voluntarily consent to such diagnostic procedures, emergency medical care and/or hospital, surgical or x-ray treatment to or upon the above named participant as may be recommended or deemed necessary by any physician, hospital, clinic or other health care provider selected by the Sierra Providence Events Center personnel and or their assistants or designees.

I further consent to allow Sierra Providence Events Center personnel and/or their assistants or designees to exercise their judgment as to whether the circumstances of such an injury or illness justify immediate medical attention or treatment by a physician, hospital, clinic, or other health care provider; and authorize the Sierra Providence Events Center personnel, assistants, or designees to arrange for the transport of the above-named participant as may be appropriate. I understand that I will be notified of the occurrence of the injury as soon as practicable. I agree to furnish to any insurance company or other third party payer, and/or their agents or representatives, copies of any and all medical or hospital records pertaining to the above participant.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Parent/Guardian if participant  
is under 18

\_\_\_\_\_  
Date