



## MEDICAL AUTHORIZATION - 2008

THIS MEDICAL AUTHORIZATION MUST BE COMPLETED BY ALL SKATERS IN ANY PROGRAM, INCLUDING ADULT WEEK.

SKATER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_

PHONES : HOME \_\_\_\_\_ WORK \_\_\_\_\_

CELL \_\_\_\_\_

ARE YOU CURRENTLY TAKING ANY MEDICATION?  NO  YES

IF YES, PLEASE LIST \_\_\_\_\_

\_\_\_\_\_

EMERGENCY MEDICAL INFORMATION (ALLERGIES/ASTHMA/PRE-EXISTING CONDITION, ETC.)

\_\_\_\_\_

\_\_\_\_\_

PHYSICIAN INFORMATION:

NAME OF PHYSICIAN \_\_\_\_\_

TELEPHONE \_\_\_\_\_

INSURANCE COMPANY INFORMATION:

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

IN THE EVENT THAT I AM UNAVAILABLE, I HEREBY GIVE PERMISSION FOR ANY MEDICAL TREATMENT FOR MYSELF (MY SON/DAUGHTER). I UNDERSTAND THAT I (MY SON/DAUGHTER) MAY BE TREATED BY THE EMERGENCY MEDICAL STAFF OF THE OLYMPIC CENTER OR BY TRANSFER TO THE ADIRONDACK MEDICAL CENTER. I FURTHER AUTHORIZE AND CONSENT TO THE RELEASE OF ANY PERTINENT MEDICAL INFORMATION AND RECORDS REGARDING THE TREATMENT, DIAGNOSIS AND/OR EXAMINATION OF MYSELF (MY SON/DAUGHTER) TO THE OLYMPIC CENTER/LAKE PLACID FIGURE SKATING – THE SKATING PROGRAM OF WHICH I AM A REGISTERED MEMBER.

SIGNATURE (PARENT/GUARDIAN IF UNDER 18) \_\_\_\_\_

PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_