



# MEDICAL RELEASE

Skater: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender \_\_\_\_\_  
 (M/F): \_\_\_\_\_  
 Parent (s)/Guardian Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Parent (s)/Guardian Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Skater's Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Country: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile \_\_\_\_\_  
 Phone: \_\_\_\_\_

**PARENT OR GUARDIAN AUTHORIZATION:**

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State/Country: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Parent Insurance Co: \_\_\_\_\_ Policy No.: \_\_\_\_\_ Group \_\_\_\_\_

ID#: \_\_\_\_\_

League Insurance Co: \_\_\_\_\_ Policy No.: \_\_\_\_\_ League/Group \_\_\_\_\_

ID#: \_\_\_\_\_

If parent(s)/guardian cannot be reached in case of emergency, contact: \_\_\_\_\_

Name Phone Relationship to Skater \_\_\_\_\_

Name Phone Relationship to Skater \_\_\_\_\_

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Frequency of Dosage \_\_\_\_\_

Date of last Tetanus Toxoid Booster: \_\_\_\_\_

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Authorized Parent/Guardian Signature Date: \_\_\_\_\_

**FOR CLUB USE ONLY:**

Club Name: Mach Racing

Club ID: GA275S

WARNING: PROTECTIVE EQUIPMENT CANNOT PREVENT ALL INJURIES a Skater MIGHT RECEIVE WHILE PARTICIPATING IN inline speed Skating.