



MSEF Medical Release Form
Fill out 1 for Each Participant
2011 – 2012

Name of Participant _____

Address _____ City _____ Zip _____

Phone _____ Date of Birth _____

Contact Lenses Y N

Emergency Contact _____ Phone _____

Physicians Name _____ Phone _____

Address _____ City _____ Zip _____

Insurance Company _____ Phone _____

Insurance Policy Number _____ Group Number _____

Insurance Company Street Address

City _____ State _____ Zip _____

Does participant have any physical problems or allergies? Circle Yes No

If yes, please explain in detail:

I hereby consent that, in case of emergency during MSEF training, including but not limited to dryland and on-snow season, (Participant) _____ may receive care without contacting or consulting me first.

Signature of Parent or Guardian

Date