

Greek Peak Ski Club  
EMERGENCY HEALTH INFORMATION FORM  
2008-2009

This form constitutes a permission statement that must be signed by a parent or guardian. All of the information on this form is confidential and will be used only for the purpose of evaluating your son's/daughter's health status and facilitating medical diagnosis, care, and/or treatment for him/her or in the processing of insurance claims in connection therewith.

**SKIER'S Name** \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACTS**

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

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

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Alternate Emergency Contacts** (other than parent(s)) \_\_\_\_\_

Relationship \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

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

**MEDICAL INFORMATION**

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Medical Conditions/Limitations: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_

ID/POLICY # \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**PERMISSION TO TREAT & TO RELEASE SUMMARY HEALTH FORM IN EMERGENCIES**

I hereby give consent for the Ski Club/Team Director or health care provider(s) considered appropriate by him/her to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my (son/daughter, ward). Should an emergency arise in which time is an important factor and the ski club's/team's authorities are unable to contact me promptly, I authorize an attending physician, ski club/team official, and/or healthcare provider to exercise their best judgement in the interests of my child's welfare.

I also give permission for this Emergency Health Information Form to be released to those ski club/team personnel or appropriate health care providers who may need this information in order to treat my son/daughter/ward in a medical emergency. Signature of

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_