Wisconsin Rapids Figure Skating Club
P.O. Box 32
Wis. Rapids WI 54495-0032

2017-2018 WRFSC Medical Release Form

As the Parent/Legal Guardian of _____, I request that in my absence, the above named skater be admitted to any hospital or medical facility for diagnosis and treatment. I request the authorized Physicians, Dentists, and staff, duly licensed as doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named skater.

Skater's Date of Birth:_____

Date of last Tetanus booster:_____

Known allergies of this skater, including any allergies to medicine:_____

Any other medical problems that should be noted:

_____

Family Physician:_____Phone Number_____

Family Dentist:_____Phone Number_____

Name of Parent/Guardian:_____Phone Number_____

Address:_____City, State, Zip:_____

Phone (home)_____Work_____Cell_____

Insurance Carrier:_____Policy Number:_____

Person to notify if Parent/Guardian is unavailable:_____

Phone (home)_____work_____cell_____

Relationship to Skater:_____

Signature of Parent/Guardian_____Date_____