MASSACHUSETTS SKI CLUB, INC
MEDICAL RELEASE

I, _____ of _____
STREET

_____
TOWN STATE ZIP CODE

_____am the parent/guardian of _____.
TEL NO.

I give and authorize the Massachusetts Ski Club, Inc., its agent, employees, or representatives to authorize medical treatment for my child, including but not limited to x-rays and medical treatment related to skiing accidents and/or emergency medical treatment recommended by hospitals or doctors.

My child's primary care physician is _____

his/her address is _____

_____
Tel. No.

I do/do not wish the physician to be contacted if treatment is required if possible.

In Witness Whereof, I have set my hand and seal this _____ day of _____ (month), _____ (year)

_____
(PLEASE SIGN AND PRINT NAME)

ANY KNOWN ALLERGIES _____
_____