

_____ cc Mt. Bachelor Ski Patrol
_____ cc MBSEF Athlete Travel File

Mt. Bachelor Sports Education Foundation



2010/2011 MBSEF MEDICAL RECORD AND RELEASE

Participant Name _____ Birth Date _____ Sex _____

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Participant Name _____ Birth Date _____ Sex _____

Local Phone # (_____) _____ Cell Phone # (_____) _____

Local Street Address _____ City _____ State _____ Zip _____

Mother's Name _____ Home # (_____) _____ Work # (_____) _____

Father's Name _____ Home # (_____) _____ Work # (_____) _____

Family Physician _____ Phone # (_____) _____ Racer's Blood Type (if known) _____

Insurance Company _____ Phone # (_____) _____ Policy # _____ ID # _____

ARE YOU SUBJECT TO OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fainting spells or dizziness | <input type="checkbox"/> Chronic bronchitis, pleurisy, or other chest disease |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Heart trouble or rheumatic disease |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Stomach or bowel trouble |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Diabetes or kidney trouble |
| <input type="checkbox"/> Operations | <input type="checkbox"/> Eye trouble, ear trouble or deafness |
| <input type="checkbox"/> Broken bones or dislocations | <input type="checkbox"/> Other conditions not listed above |
| <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> Drug reaction(s) Name drug _____ | |
| Any other condition requiring: | |
| <input type="checkbox"/> Regular medication Name condition _____ | Name medication _____ |
| <input type="checkbox"/> Restriction of activities Name activity restriction _____ | |

***If you checked any of the above items, describe fully (use separate sheet of paper if needed)

I the parent/guardian (if racer is under 18), or I the racer, give the directors and/or coaches of Mt. Bachelor Sports Education Foundation and Mt. Bachelor, Inc., permission to obtain medical aid for myself/my son/daughter in case of injury or illness and medical attention becomes necessary. It is understood that every effort will be made to contact the following designated person:

Name _____ Phone # (_____) _____ Relationship _____

Address _____

If medical attention becomes necessary, the above information is, to the best of my knowledge, true and correct.

Signed _____ Date _____ Signed _____ Age _____ Date _____

Parent/guardian (if racer is under 18)

Racer (if racer is over 18)

IN CASE OF EMERGENCY, if the designated person (above) cannot be reached, please notify:

Name _____ Phone # (_____) _____ Relationship _____