

Water Bugs Ski Club
2020 Emergency Form
(complete for all members)

1. **Participants Full Name** _____ DOB _____

Address _____ City, State, Zip _____

Phone # _____

Preferred Hospital _____

2. **Participants Full Name** _____ DOB _____

Preferred Hospital _____

3. **Participants Full Name** _____ DOB _____

Preferred Hospital _____

4. **Participants Full Name** _____ DOB _____

Preferred Hospital _____

Emergency Contacts

1. Name _____ Relation _____
Phone number _____

2. Name _____ Relation _____
Phone number _____

3. Name _____ Relation _____
Phone number _____

Insurance Information

Policy holder _____

Policy number _____ Group Number _____

Consent for Medical Treatment

As the participant, parent or legal guardian of the above named participant, I hereby give consent for medical care by a licensed Doctor of Medicine, Doctor of Dentistry, Paramedic or Certified Athletic Trainer. This care may be given under whatever conditions necessary to preserve the life, limb or well-being of the participant.

Signature _____ Date _____