NEW PALTZ HS **Medical Information**

This authorizes a licensed physician, surgeon, emergency medical technician, paramedic, ski area medical personnel or other recognized hospital staff to carry out emergency medical care deemed necessary for my child/ward in an emergency when normal permission is unavailable. PLEASE MAKE COPIES IF YOU DON'T HAVE RELEASE.

Signature of parent or guardian ______________________________ Date____________

Print name of parent/guardian____

Medical insurance: Company____

Policy Number____

Family physician______________________________ Phone # (_____) _____-______

Special instructions: Drug allergies, epilepsy, diabetes, heart trouble, contact lenses etc.

____

Name of student (print)____

Address_____________________________________ City___________________ State_____

Phone (_______) ________-________ Birth date _____/_____/_____ Grade_____

Emergency contact: Name (print)____

Phone (_______) ________-_________ Parent's cell phone (_______) _______-_____

Equipment information if you are bringing own skis or board

Brand and model(Skis) (Board)________________________________ Color_________

Serial # if available____

Phone (_______) ________-_________

<u>THIS INFORMATION SHOULD BE KEPT BY TOUR LEADER, NOT GIVEN TO CATAMOUNT</u>

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