

**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.

\_\_\_\_\_  
Insurance

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)