DO NOT MAIL OR EMAIL! BRING TO CHECK-IN On 1st DAY

BANDIT GOALIE SCHOOL - 2019

Please note the information below from Bandit Goalie School, regarding health care:

Please fill out this form COMPLETELY. It is important for the provision of proper medical care. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician or staff member will try to contact the parents to inform them of the problem and discuss treatment. Occasionally, we are unable to reach parents immediately. The parent's signature on the medical treatment authorization below allows treatment in these circumstances.

Dates attending:_____Camp Location_____ Program_____

(Please Print)

I. PERSONAL INFORMATION - ATTENDING STUDENT

Name:_____

Date of Birth:_____ Age: ___ Sex: Male____ Female____

Home Address: _____

Home phone: ( )_____Parent Cell phone: ( )_____

In case of emergency notify: _____

Home phone: ( )_____ Cell phone: ( )_____ Office phone: ( )_____

Alternate Contact Information: _____
(name of parent or next of kin) (relationship)

Home phone: ( )_____ Cell phone: ( )_____ Office phone: ( )_____

Family Physician:_____ Phone: _____

II. BACKGROUND

Please provide any pertinent information regarding your child's current health, past medical history, and/or medications taken, that may help us better coach your child and which can assist medical staff should an emergency occur.

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Student's Name: _____ **(please print)**

Please list any medications being taken and include dose & frequency.

Have you ever had any of the following: (please check)

_____ Asthma _____ Epilepsy _____ Diabetes _____ Bleeding disorder _____Heart condition

III. INSURANCE INFORMATION (Participant **must** be covered by a health insurance policy.)

Primary Medical Insurance:

Company Name: _____

Company Address: _____

_____

Ins. Company phone: _____

Med. Ins. Policy Number: _____

Med. Ins. Group #: _____

Name of person insured: _____

DOB of insured: _____

SS# of insured: _____

Employer of insured: _____

Dental Insurance:

Company Name:_____

Company Address: _____

_____

Ins. Company phone: _____

Dental Ins. Policy Number:_____

Dental Ins. Group #:_____

Name of person insured: _____

DOB of insured: _____

SS# of insured: _____

Employer of insured: _____

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IV. MEDICAL TREATMENT AUTHORIZATION AND LIABILITY RELEASE

I, the undersigned acknowledge that I am the parent or guardian of ("the Student"), and do hereby grant my permission for the Student to attend a Bandit Goalie School camp, and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize Bandit Goalie School and/or the local hospital to provide the needed medical treatment they deem necessary. I hereby release Stan Matwijiw, all members of the staff, the host ice facility and its staff, the local hospital and their doctors, agents, employees, and representatives, and all officers of Bandit Goalie School, from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to me, or my insurance company, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical illness or injury and that I, as parent or guardian of the Student, am assuming the risk of such injury by his/her participation and release Stan Matwijiw, the staff, the Host Ice Rink and it's staff, and all affiliated with or participating in the Bandit Goalie School, from all liability, claims, obligations or responsibility for personal property losses, accidents or injuries of any kind. I understand the inherent risks of the training process for being a goalie and recognize that the program is strenuous. I have received a copy of the schedule and understand the activities. I understand that full, legal equipment is to be worn properly at all times on ice or on the bench. I further authorize the staff to administer non-prescription analgesics for minor medical problems such as headaches, etc. unless I have requested otherwise.

Dated: _____

_____

Parent / Guardian Signature And Relationship To The Student's Signature

_____ _____