



**MEDICAL
CLEARANCE FORM**

2017-18 Season

Participant Name: _____	Age: _____	DOB: _____
Address: _____	City: _____	Zip: _____
Phone: _____	Emergency Contact/phone: _____	

Disability:
Medical Problems:
Previous Surgeries:
Current Medications:
Allergies:

I agree that this person is medically fit to participate in a disabled ski/snowboard program: YES or NO (circle one)

Special restrictions or precautions:

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____

Phone: _____