MEDICAL CLEARANCE FORM

2019-20 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:_____