CRIMSON HOCKEY CLINIC

June 14 – June 16, 2019

Medical Form

Participant Name: _____

Home Address: _____

Home Phone: (_____) _____

Parent/Guardian Name: _____ Work Phone: (_____) _____

Address (if different): _____

Insurance Company: _____

Name of Policy Holder: _____ Relation to Camper: _____

Group Number: _____ Policy/ID Number: _____

Emergency Contact: _____ Phone Number: (_____) _____

Medical Information: To be Completed by Physician:

Medications: _____

Allergies to Medications: _____

Medical Conditions: _____

Date of most recent immunizations: Tetanus: _____ Measles: _____ Mumps: _____

Rubella: _____ Diphtheria: _____

I have examined _____ and herby certify that she is able to participate in the athletic activities without restriction.

X_____ _____ (_____) _____
Physicians Signature Date Phone

Medical Authorization

Authorization for Treatment of a Minor: If the participant listed above is less than 18 years old, please sign and have witnessed the statement below:
In the event of an injury or illness, I give permission for my child, _____, to be treated by a member of the Crimson Hockey Clinic Staff, Certified Athletic Trainer on site, and/or Mt. Auburn Hospital Emergency Center.

X_____ _____ X_____ _____
Signature of Parent/Guardian Date Signature of Witness Date

Please return via mail (65 N. Harvard St. Boston, MA 02163), or via email (thecrimsonclinic@gmail.com) by **June 1, 2019**.

Without this waiver, athlete may NOT participate.