

**NANTUCKET SKATING CLUB  
MEDICAL FORM**

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Name of Insured \_\_\_\_\_

Emergency Contacts:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Special Condititons \_\_\_\_\_

Allergies \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

Current Medication(s) if any \_\_\_\_\_

I, the undersigned do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that effort shall be made to contact the undersigned prior to rendering to the patient, but that any and all of the above treatment will not be withheld if the undersigned cannot be reached.

Signed \_\_\_\_\_ Dated \_\_\_\_\_

**I UNDERSTAND THAT IF MY CHILD IS AGE 10 (TEN) OR UNDER, I MUST HAVE A PARENT/GUARDIAN OR RESPONSIBLE ADULT AT THE RINK AT ALL TIMES. NEITHER THE CLUB, ITS MEMBERS, OR PROFESSIONALS ARE RESPONSIBLE FOR INJURIES OR DISCIPLINE.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian