



## PNW MEDICAL RELEASE

**2026-27**

WE DO HEREBY AUTHORIZE any licensed physician and/or responsible staff member of any hospital in any state to administer whatever medical or surgical treatment, or therapeutic procedures they deem necessary for the diagnosis and treatment of \_\_\_\_\_ (THE SKIER). We consent to any examination, administration of any medication or anesthetic and medical and/or surgical treatment or other hospital services rendered under the general or special instruction or supervision of such physician or hospital staff person. This release is valid for the period from July 1, 2026 to June 30, 2027.

Every effort is made to contact parents or legal guardians of SKIER in the event emergency medical care is needed. Some hospitals, however, will not accept verbal authorization for treatment. Therefore, we suggest that parents fill out this form and send it to the PNW Office.

SKIERS WHO WISH TO TRAVEL AS PART OF THE DIVISIONAL TEAM MUST SUBMIT THIS COMPLETED FORM.

INSURANCE CO.: \_\_\_\_\_ POLICY # \_\_\_\_\_

Please list any medical conditions your racer has that the Coaching Staff should be aware of. (Drug Allergies, Diabetes, Heart Trouble, Asthma, Medications, Injuries, Food Allergies, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of Emergency, please notify:

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

DATED: \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Signature of the Skier / Athlete)

ADDRESS: \_\_\_\_\_ Phone (Wk) \_\_\_\_\_

\_\_\_\_\_ Phone (Hm) \_\_\_\_\_

\_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Email: \_\_\_\_\_ FAX: \_\_\_\_\_