

SOUTHEASTERN WISCONSIN ALPINE TEAM RACING, INC.
ATHLETIC PARTICIPATION FORM

ALL MEMBERS participating in the Southeastern Wisconsin Alpine Team Racing Program must have this form on file with the office of S.W.A.Team Racing, completed and signed prior to the first practice.

POWER TO AUTHORIZE MEDICAL TREATMENT

We/I, the undersigned, as parent(s) and/or legal guardian of _____ (“my child”) do recognize that medical treatment may become necessary during my child’s participation with S.W.A.Team Racing, Inc. and to avoid delay of any necessary medical treatment and/or that which would alleviate physical discomfort attendant to physical injury, HEREBY EMPOWER the coaches and staff of S.W.A.Team Racing, Inc. or other designated persons to authorize on my behalf recommended medical treatment of my child by any staff member of any hospital, medical doctor, emergency medical technician and/or other paramedic. This AUTHORIZATION is complete in and of itself and is fully operative upon my signature for the duration of my child(s) participation with S.W.A.Team Racing, Inc.

PARTICIPANT’S NAME: _____ Age: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Print Father’s Name & Sign _____ Print Mother’s Name & Sign _____

Father’s Phone at Work: (_____) _____ Cell: (_____) _____

Mother’s Phone at Work: (_____) _____ Cell: (_____) _____

Childs/Family Physician: _____ Phone: (_____) _____

Dentist’s Name: _____ Phone: (_____) _____

If parent(s) are not available, additional person we can contact in case of an emergency:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Southeastern Wisconsin Alpine Team Racing, Inc. requires that all participating athletes have insurance coverage prior to any CLUB practice, event or competition. Please state the name of your Insurance Company, Policy Holder’s Name & Policy number below:

PRIMARY INSURANCE COMPANY: _____

Policy Holders Name: _____ ID# _____

SECONDARY INSURANCE COMPANY: _____

Policy Holders Name: _____ ID# _____