

**RELEASE**

I/we, the undersigned, individually and as parent(s) and/or guardian(s) of \_\_\_\_\_, a minor, ask that he/she be admitted to participate in this skating camp sponsored by the Metro Edge Figure Skating Club and Hardee's IcePlex. In consideration of such admission, I/we do hereby agree to release, discharge, and hold harmless Metro Edge Figure Skating Club and Hardee's IcePlex, their officers, agents, and employees of and from any and all causes, liabilities, damages, claims, or demands whatsoever on account of any injury or accident involving the said minor arising out of the minor's attendance at the skating camp or in the course of competition and/ or activities held in connection with the skating camp.

Both signatures requested: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Mother's/guardian's signature\_\_\_\_\_  
Father's/guardian's signature**EMERGENCY HEALTH**

Skater's Last name	First name	Middle initial	( ) Male	( ) Female
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\_\_\_\_\_  
Home phone with A/C\_\_\_\_\_  
Cell phone with A/C\_\_\_\_\_  
Street Address

City	State	ZIP code
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\_\_\_\_\_  
Mother's/guardian's daytime phone \_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_  
Father's/guardian's daytime phone \_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_  
Cell phone (if applicable) \_\_\_\_\_**MEDICAL TREATMENT AUTHORIZATION**

I hereby authorize the staff of STL Summer Skating Camp and Hardee's IcePlex to administer minor medical treatment as necessary to my son/daughter, \_\_\_\_\_.

I understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the camp. I hereby release the Metro Edge Figure Skating Club Hardee's IcePlex, their officers, staff, agents, and employees from any and all claims and liability arising in anyway out the exercise of this authority. Physical conditions that the camp should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

\_\_\_\_\_  
Date of most recent tetanus immunization: \_\_\_\_\_

(If more than ten years ago, a booster shot is recommended.)

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency, and if I cannot be reached, I understand my son/daughter will be taken to the nearest hospital, and I consent for the physicians and staff at the emergency facility to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

\_\_\_\_\_  
Name of emergency contact\_\_\_\_\_  
Telephone with Area Code\_\_\_\_\_  
Name of family physician\_\_\_\_\_  
Telephone with Area Code\_\_\_\_\_  
Parent's or guardian's name (please print)\_\_\_\_\_  
Parent's or guardian's signature**PLEASE ATTACH A COPY OF YOUR INSURANCE CARD**\_\_\_\_\_  
Insurance company\_\_\_\_\_  
Insurance company address (no. and street or box no.)

City	State	ZIP code
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\_\_\_\_\_  
Policy subscriber's name\_\_\_\_\_  
Policy no.\_\_\_\_\_  
Group no.