Minneapolis Alpine Ski Team
Power To Authorize Medical Treatment
2012-2013

I, the undersigned, as parent and/or legal guardian of _____, ("my child") do recognize that medical treatment may become necessary during my child's travel and participation with the Minneapolis Alpine Ski Team ("MAST") 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 MAST, 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 MAST.

Signed:_____ Date: _____

Signed: _____Date: _____

Insurance Company: _____

Policy Number: _____

Group Number: _____

Doctor's Name and Phone:

Preferred Hospital:

Known Allergies and Medical Conditions:

Medications:

Emergency Contacts:

	Name	Phone Numbers
1.		
2.		
3.		