



NORWAY, MICHIGAN
INDIANHEAD MT., MICHIGAN
A-BASIN, COLORADO

WWW.NORWAYMOUNTAIN.COM/TEAMNORWAY

MEDICAL RELEASE FORM

Athlete's Name: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State/Province: _____ Zip: _____

Home Telephone Number: _____

Father's Name: _____ Phone No.: _____

Mother's Name: _____ Phone No.: _____

TEAM NORWAY requires that all participating athletes have insurance coverage prior to any "team" activity on and/or off snow. Please state the name of your insurance company, the policyholder's name, and policy numbers below.

PRIMARY INSURANCE COMPANY: _____

Policy Holders Name: _____ GROUP NO. _____

Policy Number: _____

MEDICAL CONDITIONS OF THE ATHLETE WE SHOULD BE AWARE OF: _____

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

Name: _____ Relationship: _____

Address: _____ City: _____ State/Province: _____

Phone No.: _____ Cell No.: _____