

The Central New York Ski Racing Foundation
2009 - 2010 Registration form (one per racer)

Racer's Name _____

Address _____

City _____ State _____ Zip _____

E-mail address: _____

__ male __ female Birth date _____ Age _____

Phone (_____) _____

Parents Name(s) _____

Years Skiing _____ Years Racing _____ Level _____

Membership Preference

Race Program

Race program: Parents are required to work at least 2 ski team hosted races held at Song. Minimum one adult per race. Parent signature required acknowledging this obligation.

Signature: _____

Assignments will be provided during Christmas Camp.

_____	Jl, Jll (15-19 years)	\$475.00
	Jlll (13-14 years)	\$425.00
_____	JIv (11-12 years)	\$350.00
	JV (9-10 years)	\$325.00

Development Program

Parents are required to work at least 1 ski team hosted race held at Song. (See details above)

Signature: _____

_____ Development Team \$250.00

Saturday 10-12 and 1-3pm
Sunday 10-12 and 1-3pm

Mail Check or Money Order to: CNYSRF, P.O. Box 831, Tully, NY 13159

Official use only: CHECK #

Am't:

DATE:

MEDICAL HISTORY QUESTIONNAIRE

NAME _____

DATE OF BIRTH _____ SEX _____ RACING LEVEL _____

ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____

PLEASE CIRCLE "YES" OR "NO" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON BOTH SIDES THIS FORM. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

1. Are you allergic to any medication ? (aspirin, penicillin, sulfa, etc.)
NO / YES List _____
2. Do you take any prescribed medication on a permanent or semi-permanent basis ? (steroids, birth control pills, anti-inflammatories, anti-biotic, etc.)
NO / YES List _____
3. Have you ever had an epileptic seizure ?
NO / YES _____
4. Have you been told by a doctor that you have epilepsy ?
NO / YES (list medication) _____
5. Have you ever been treated for diabetes ?
NO / YES (list medication) _____
4. Have you ever been told by a doctor that you were anemic ?
NO / YES If so, when? _____
7. Have you ever been told by a doctor that you have sickle cell anemia ?
NO / YES _____
8. Do you have, or have you ever had high blood pressure ?
NO / YES (list medication) _____
9. Do you have, or have you ever had the following diseases ?
NO / YES Date _____ Heart disease (heart murmur, rheumatic fever)
NO / YES Date _____ Lung disease (pneumonia)
NO / YES Date _____ Kidney disease (infections)
NO / YES Date _____ Liver disease (mononucleosis, hepatitis)
10. Have you ever been told by a doctor that you have asthma ?
NO / YES (list medication) _____
11. Do you , or have you had a hernia or "rupture" ?
NO / YES If so, has it been repaired : Date _____
12. Have you been "knocked out" (unconscious) in the last 3 years ?
NO / YES (list dates) _____
13. Have you had a concussion or other head injuries in the past 3 years ?
NO / YES (list dates) _____
14. Have you stayed overnight in a hospital due to a head injury ?
NO / YES (list dates) _____

MEDICAL HISTORY QUESTIONNAIRE

15. Have you had a neck injury involving bones , nerves or discs that disabled you for a week or more ?
NO / YES Type of injury _____
16. Do you wear glasses or contact during competition ?
NO / YES
17. Do you wear any of the following dental appliances : PERMANENT BRIDGE , BRACES , REMOVABLE RETAINER , REMOVAL PARTIAL PLATE , FULL PLATE , PERMANENT CROWN OR JACKET ?
NO / YES Circle those which apply ?
18. Have you had a broken bone or fracture in the past 2 years ?
NO / YES Which bone _____ Date _____
19. Have you had a shoulder injury in the past 2 years that disabled you for a week or longer ? (dislocation , separation)
NO / YES R ___ or L ___ Type of injury _____ Date _____
20. Have you ever had shoulder surgery ?
NO / YES What was done & why ? _____ Date _____
21. Have you ever injured your back ?
NO / YES Type of injury _____ Date _____
22. Do you have back pain ?
NO / YES (circle those which apply) Seldom / Occasionally / Frequently / With Vigorous Exercise / Heavy Lifting
23. Have you injured your knee in the past 2 years ?
NO / YES
24. Have you ever been told by a doctor / athletic trainer that you injured the cartilage in your knee ?
NO / YES
25. Have you ever been told by a doctor / athletic trainer that you injured the ligaments in your knee ?
NO / YES R _____ or L _____ Date _____
26. Have you ever had knee surgery ?
NO / YES R _____ or L _____ Date _____
27. Have you had a severe ankle sprain in the past 2 years ?
NO / YES
28. Do you have a pin , screw , or plate in your body ?
NO / YES Describe where _____
29. Do you have any other conditions which we should be aware of ?
(i.e. ulcers , pregnancy , food / insect allergies , tendinitis)
NO / YES (Specify & give details) _____
30. DATE OF LAST TETANUS & POLIO SHOTS : _____

THE QUESTIONS ON BOTH SIDES OF THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE .

SIGNATURE

DATE

CNYSRF Medical Information Form - 2010

Note: No racer will be allowed to practice or race with the team unless this form is returned.

Name: _____ Racing Level (e.i. JI-II) _____

Address: _____

City _____ Zip _____

Telephone: _____

Birth date (M/D/Y): _____ Age: _____

Mother's Name: _____

Address/Home Phone (if other than above):

Mother's Work Phone: _____

Father's Name: _____

Address/Home Phone (if other than above):

Father's Work Phone: _____

Emergency Contact (other than parents): _____

Phone: _____

Health Insurance Carrier: _____

Policy #: _____

Are you taking any medications? _____

Do you have any allergies? _____

Please give the date of your last immunization for Tetanus _____

Are you up-to-date on all other immunizations as required by New York State Department of Education athletic policies?

Yes _____ No _____

Is there anything medically we should know about? Please be specific.

*Please read the authorization on the reverse side, sign and return as soon as possible.
Thank you.*

AUTHORIZATION FOR THIRD PARTY

(To consent to treatment of minor lacking capacity to consent)

I/we, the undersigned, parent(s)/person having legal custody of/legal guardian of

_____ a minor, do hereby authorize the Central New York Ski Racing Foundation as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required by is given to provide authority to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of his/her best judgment deem advisable.

I/we hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to my/our above named agent(s) upon completion of treatment.

These authorizations shall remain effective until April 30, 2010 unless sooner revoked in writing delivered to said agent(s).

Signature of parent(s)/legal guardian(s)/person(s) having legal custody

_____ Date _____

_____ Date _____

If signed by other than parent, please indicate relationship. _____