

The Central New York Ski Racing Foundation  
2010 - 2011 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:
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## 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 - 2011

*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, 2011 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. \_\_\_\_\_

10/24/10