



SPECTRUM WINTERGUARD MEDICAL AND SURGICAL AUTHORIZATION

Performer's Name _____ **Birth Date** _____

Home Address _____

City State Zip _____

Social Security # ____ - ____ - _____ (required by medical personnel for treatment)

Is the performer allergic to any medication and/or food? Yes No

Please list: _____

May this performer take **aspirin**? Yes No Does this performer wear **contact lenses**? Yes No

Does this performer suffer from: **Hay fever** Yes No **Allergies** Yes No **Asthma** Yes No

Does this performer take any **medication**? Yes No Please list:

Please describe any health history that may assist the person in charge should this performer become ill:

Family Physician _____ **Phone:** _____

Address: _____

City ST Zip: _____

In case of emergency, please contact: _____

Relationship: _____ **Phone:** _____

Parent/Guardian: _____ **Phone:** _____

Address: _____

We do We do not have health or accident insurance

Insurance Company

Name: _____

Group Number Policy Number of Group: _____

I hereby authorize medical or surgical treatment of above named Performer in the event of any emergency, illness or accident. I accept all responsibility and liability for any occurrence during this Performer's participation with Spectrum Winterguard.

Signature of parent, guardian or performer (if over 18 years of age) Date _____