AUTHORIZATION FOR EMERGENCY TREATMENT OF MINOR

I, _____, authorize the Vail Valley Medical Center, or other emergency medical provider, including its agents, employees and any members of its medical staff, to render emergency medical care to my child/legal ward (hereinafter "Child" or "Skier"), _____, as is considered in their medical judgment to be necessary or beneficial. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.

This Authorization is made to be effective throughout the entire 2017 – 2018 skiing season.

DRUG(s) & ALLERGIES (IF ANY): _____

_____

A copy of this authorization shall be deemed an original, and signatures may be delivered by facsimile and/or email and the parties hereto agree to accept and be bound by a copy and/or facsimile/email signatures hereto.

SIGNATURE of PARENT/LEGAL GUARDIAN: _____

DATE: _____

Witness: _____

CHILD/SKIER HEALTH INSURANCE INFORMATION:

Regular Doctor or Health Care Provider: _____

Telephone: _____

Insurance Company Name: _____

Insurance Company Address: _____

Policy Number: _____

Insured Name: _____