

**Consent for Medical Attention or Treatment**

I certify that I, the member, or I, the parent/guardian of said participant, give my consent to the **Ozark Figure Skating Club** and the facility the activities are taking place in and their staff and to members of the **Ozark Figure Skating Club**, their Board of Directors and volunteers to obtain medical care from any licensed physician, hospital or clinic, including transportation and emergency medical services, for myself/ourselves and/or said participant for any injury that could arise from participation in these activities.

\_\_\_\_\_  
Name of 1st Member (please print)

\_\_\_\_\_  
Name of 2nd Member (please print)

\_\_\_\_\_  
Name of 3rd Member (please print)

\_\_\_\_\_  
Name of 4th Member (please print)

\_\_\_\_\_  
Name of Parent/Guardian (Please Print)

\_\_\_\_\_  
Signature of Member (18 or Older) OR Parent/Guardian

\_\_\_\_\_  
Date

This Consent for Medical Attention shall be binding and effective for the \_\_\_\_\_ membership year of **Ozark Figure Skating Club**.