



Bill Koch Youth Ski League
Southwest New Hampshire
• Keene • Windblown • Bedford

Southwest New Hampshire District Membership Application

Last Name _____ First Name _____

Date of Birth _____

Male Female

Address _____

Town _____ State _____ Zip _____

Telephone _____

Email _____

Name of Parent(s) or Guardian(s) 1) _____

2) _____

Experience Level _____

- I will volunteer for:
- | | |
|---|---|
| <input type="checkbox"/> An assistant coach | <input type="checkbox"/> Write news release |
| <input type="checkbox"/> Drinks and snacks | <input type="checkbox"/> Event organization |
| <input type="checkbox"/> Treasurer | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Other _____ |

Signature of parent or guardian _____ Date _____

| | | |
|-------------------|-------|--------------------------------|
| SWNH District Fee | _____ | \$20 |
| Club Fee | _____ | |
| Total | _____ | (make checks out to SWNHBKYSL) |

Medical Information & Release Form

CHILD'S NAME _____ DOB: _____

PARENT'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

KNOWN ALLERGIES: _____

MEDICAL/DENTAL CONDITIONS: _____

MEDICATIONS: _____

INSURANCE COMPANY: _____

BILLING ADDRESS: _____

PHONE: _____ POLICY HOLDER: _____

ID #: _____ GROUP NUMBER: _____ PLAN CODE: _____

DENTAL INSURANCE COMPANY: _____

BILLING ADDRESS: _____

PHONE: _____ POLICY HOLDER: _____

ID #: _____ GROUP NUMBER: _____ PLAN CODE: _____

PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

DENTIST: _____ PHONE: _____

ADDRESS: _____

We, _____, (Parents) hereby give permission for any and all medical and/or dental attention to be administered to our child _____ in the event of accident, injury, sickness, etc., under the direction of the bearer of this letter, until such time as we may be contacted. We also assume the responsibility for the payment of any such treatment.

Parent's Signature

Date

Parent's Signature

Date