



2019-2020
Mt. La Crosse Ski Team
Registration Form

*Please Print Clearly

Today's Date _____

Athlete's Full Name _____
(first) (middle) (last)

Age_____ **DOB**_____ **MALE OR FEMALE (Circle)**

Years Skiing_____ **Years Racing:**_____ **USSA Number:**_____ (if applicable)

Athlete's Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Athlete's Ph._____ **Athlete's Home Ph.**_____

Athlete's Email: _____

Father/Guardian's Name _____

Email Address: _____

Phone Number: _____

Mother/Guardian's Name _____

Email Address: _____

Phone Number: _____



Program Registration

Please indicate program you are registering for by placing an X by the selection. Refer to the attached program description pages for details.

- “D”evelopment Program \$390_____
- Training Program \$540_____
- Training Lite Program \$425_____
- High School Bonus Training Program
 - \$300_____
 - \$150_____

- Traveling Program \$1,350_____
- Hybrid Traveling Program \$990_____

*Please indicate which races including dates or if unsure please let Coach Mikkelson know by December 1st:

Race #1: _____

Race#2: _____

Race#3: _____

- “D”evelopment Program + Pinski/Benjamin Cup \$540_____
- Training Program + Pinski/Benjamin Cup \$690_____
- Training Lite Program + Pinski/Benjamin Cup \$575_____
- FIS Racing Program \$1,950_____

*Please ensure the medical information and waiver is included with your registration

PLEASE SEND FORMS AND PAYMENT BY NOVEMBER 18TH TO:

MLST
c/o John Moore
1630 Losey Blvd. S.
La Crosse, WI 54601

MEDICAL INFORMATION

**Please provide a copy of your insurance*

Physician:		Hospital Preference:	Phone number: ()
Insurance Carrier:		Phone number: ()	
Subscriber's name:	Birth Date: / /	Group number:	Policy number:
Seconday Insurance:	Subscriber's name:	Group number:	Policy number:

**If there are any injuries, illnesses or health concerns that may affect participation, please include the informaion on an attached document.*

IN CASE OF EMERGENCY:

Emergency Contact: <i>(if parents cannot be reached)</i>	Relationship to Athlete:	Home/cell number: ()	Work phone number: ()
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POWER TO AUTHORIZE MEDICAL TREATMENT

I, the undersigned, as and/or legal guardian of _____ ("my child") do recognize that medical treatment may become necessary during my child's travel and participation in the **La Crosse Area Youth Ski Association**, herby referred to as "LAYSA", and to avoid delay of any necessary medical treatment and/or that which would alleviate physical discomfort attendant to physical injury, HEREBY EMPOWER the coaches of the LAYSA, or other designated persons to authorize on my behalf recommended medical treatment of my child by any staff member of any hospital, medical doctor, emergency medical technician and/or paramedic. This AUTHORIZATION is complete I and of itself and is fully operative upon my signature for the duration of my chid's participation with **LAYSA**.

Patient/Gaurdian Signature:

Patient/Guardian Signature:

RELEASE OF CLAIMS

We, _____ and _____ parents or guardians of _____ understand that competitive ski racing, practicing for ski racing and all of the activities taking place in order to prepare for ski racing are dangerous and physically demanding activities and that serious personal injuries are a possibility. We accept the inherent dangers of physical participatoin in such activities and do hereby agree to allow his/her participation in such activities and do hereby release the **La Crosse Area Youth Ski Association, its incorporators, directors, contractors, and coaches, Mt La Crosse, and any and all other present or future employees, coaches, contractors, and all volunteers**, who are assisting with the management or operation of either corporation or its activities, in any way, and agree to hold said parties free from any and all claims, demands, causes of action, and/or attorney fees arising out of or in any way related to any personal injury or property damage sustained by/to our child while being transported to or from such activites or while involved in such activities. We have read and understand this release and voluntarily, willingly, and knowingly, have signed this release as evidence of our agreement to all its terms.

Patient/Gaurdian Signature:

Patient/Guardian Signature: