

# WATER SKI CLINIC INFORMATION

NAME:

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ADDRESS:

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PHONE NUMBERS:

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EMERGENCY CONTACT PERSON & NUMBER:

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DISABILITY:

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IF SKIING, PREFERRED TIME TO SKI:    AM    OR    PM

ARE THERE ANY LIMITATIONS, SPECIFIC MEDICAL PROBLEMS, ETC THAT WE SHOULD BE AWARE OF:

PLEASE STATE ANY OTHER INFORMATION THAT YOU FEEL IS PERTINENT. INFORMATION WILL BE KEPT CONFIDENTIAL:

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Mailing address:

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