MEDICAL CONSENT FORM

Each participant must complete and sign a copy of this form. Please fill it out completely. Incomplete forms will not be accepted.

NAME OF PARTICIPANT: ____

NAME OF PARENT OR GUARDIAN (**if under 18**): ____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child if named above as the "Participant") or in the event of illness of myself, my spouse or any child of mine while in, on or about the premises of the ____________________________ Club or while participating in any activity sponsored by or under the auspices of the _________________________ Club under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.
2. I authorize the General Manager, Assistant General Manager or any officer or member of the Club to consent to such medical care, attention or treatment.
3. I agree to pay all costs of such medical care, attention or treatment and to hold free and harmless of and from any and all liability for such cost the Club, the United States Sailing Association and the officers and members of each.

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed by the State of ___________ or of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Participant Signature: ____

Parent/Guardian Signature (**if under 18**): ______________________________________ Date: _______________

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER
		( )
		( )

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	PHONE NUMBER	DATE OF LAST EXAM
	( )	

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

PLEASE FILL OUT THE NEXT PAGE

MEDICAL AND EMERGENCY INFORMATION

Participant's name: ____ Male ____ Female ____

Address: ____

City/State/Zip: ____

Cell phone: (_______)____________________________ Home phone: (______)________________________

Date of Birth: ___________________________________

THE PARTICIPANT AND/OR THEIR PARENT(S) MUST RESPOND TO THE FOLLOWING QUESTIONS AS ACCURATELY AND COMPLETELY AS POSSIBLE:

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:		ALLERGIES:	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		MEDICATION (please list below)	
DIABETES OR HYPOGLYCEMIA		LATEX	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		BEE STINGS/INSECT BITES	
CIRCULATORY OR HEART PROBLEMS		IF YES, DO YOU CARRY AN EPI-PEN?	
EPILEPSY/ SEIZURE		FOODS	
OTHER		OTHER	

DATE OF LAST TETANUS / DIPTHERIA / TOXOID SHOT: ________________________________

CURRENT MEDICATIONS AND DOSAGE, IF ANY: ______________________________________

____

____

DETAILS: ____

____

____

____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION.
If any of the above mentioned information changes before or during the event, please submit in writing all pertinent information to the regatta chairperson.