Medical Consent Form

This signed consent form MUST be on file in order to complete registration. One must be on file for each sailor.

NAME OF PARTICIPANT (printed):_____

NAME OF PARENT OR GUARDIAN (printed): _____

In the event of any accident or injury to the minor named above as the Participant, or in the event of any illness of the minor named above as the Participant, while participating in the Candlewood Yacht Club Junior Sailing Program or while on the premises of the Club, if I, as parent or guardian, am not present:

1. I hereby voluntarily consent to the furnishing to the minor named above of emergency first aid and such other medical care and treatment by any hospital or physician(s) as the hospital or physician(s) deem necessary or advisable, or necessary, including, without limitation, x-ray examination, anesthetic, and diagnostic procedures.
2. I authorize any officer or member of the Club to consent to such medical care or treatment.
3. I agree to pay the cost of such medical care or treatment and to hold the Club and its officers and members harmless from liability for such cost.
4. I give this authorization in advance of any specific diagnosis, treatment, or hospital care being required in order to provide authority to render such care as the physicians rendering such care may, in their best judgment, deem advisable.

I understand that all efforts shall be made to contact me in the event of accident or injury to, or illness of, the minor named above, but medical care and treatment will not be withheld if I cannot be reached.

Signature of Parent/Guardian:_____ 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

List here all allergies or medical conditions affecting the Participant:

Medical And Emergency Information

NAME:_____ SEX _____ (M) _____ (F)

ADDRESS:_____ *Street/P.O. Box*

_____

City *State* *Zip*

PHONE: _____ (home) _____ (emergency cell)

DATE OF BIRTH: _____

THE PARTICIPANT AND THEIR PARENTS MUST ANSWER 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	
DIABETES OR HYPOGLYCEMIA		LATEX	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		BEE STINGS/INSECT BITES	
CIRCULATORY OR HEART PROBLEMS		IF YES, DO YOU CARRY AN EpiPen?	
EPILEPSY/SEIZURE		FOODS	
OTHER		OTHERS, IF SIGNIFICANT	

DATE OF LAST Tdap (Tetanus/Diphtheria/Acellular Pertussis) SHOT: _____

CURRENT MEDICATIONS AND DOSAGE, IF ANY: _____

DETAILS: _____

_____

_____

ATTACH A COPY OF YOUR HEALTH INSURANCE CARD TO THIS FORM.