MEDICAL CONSENT FORM

NAME OF PARTICIPANT:

NAME OF PARENT OR LEGAL GUARDIAN:

In the event of accident or injury to myself, my spouse, or any child of mine (specifically including my child 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 Kaneohe Yacht Club or while participating in any activity sponsored by or under the auspices of Kaneohe Yacht 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 or any officer or member of Kaneohe Yacht Club and/or Hawaii Youth Sailing Association (HYSA) 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 Kaneohe Yacht Club, HYSA and the officers and members of each free and harmless of and from any and all liability for such cost.

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 Hawaii or of any hospital holding a current operating certificate 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/her 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.

Signature: _____

Parent/Guardian Signature: _____ Date: _____

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

PHYSICIAN/DENTIST INFORMATION:

NAME	POSITION	PHONE NUMBER
	PHYSICIAN	
	DENTIST	

PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD TO THIS FORM

MEDICAL EMERGENCY INFORMATION

PARTICIPANT'S NAME: _____ Male ____ Female ___

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ (home) _____ (Emergency Cell) DATE OF BIRTH:_____

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

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

CHRONIC AILMENTS:		**ALLERGIES:**	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		MEDICATION (list below)	
DIABETES OR HYPOGLYCEMIA		LATEX	
HEMOPHILIA OR OTHER BLEEDING PROBLEMS		BEE STINGS/INSECT BITES	
CIRCULATORY OR HEART PROBLEMS		FOOD (list below)	
EPILEPSY/SEIZURE		DO YOU CARRY AN EPIPEN?	
OTHER		OTHER	

DATE OF LAST TETANUS/DIPTHERIA/TOXOID/T/d or Tdap SHOT: _____

CURRENT MEDICATION AND DOSAGE IF ANY: _____

_____

DETAILS: _____

_____

DIETARY RESTRICTIONS: _____

_____

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

PLEASE RETURN FORMS TO:

BY EMAIL TO : imu.regatta@gmail.com
BY MAIL TO: Imu Regatta, c/o Jill Tsuchitori, 3417 Loulu Street, Honolulu, Hawaii 96822