# 2019 Medical Consent & Release Form

**NAME OF PARTICIPANT (printed):**_____

**NAME OF PARENT OR GUARDIAN (printed):** _____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named above as "Participant") or in the event of illness of myself, my spouse or any child of mine while on or about the premises of the Host Club/Organization while participating in an event under the auspices of the Host where I am unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse or any child of mine of such medical care and treatment by any hospital or physician(s) as the hospital or physician(s) deem necessary or advisable.
2. I authorize any officer or member of the Host to consent to such medical care or treatment.
3. I agree to pay the reasonable cost of such medical care or treatment and to indemnify and hold free and harmless of all liability for such cost the Host and US SAILING and its officers and members.

I hereby authorize any x-ray examination, anesthetic, medical or surgical diagnosis or procedure supervised by any member of the medical staff or of a dentist licensed under the State Education Law and/or Public Health Law of the State and of the staff of any hospital holding a current operating certificate issued by the State Department of Health. This authorization is given in advance of any specific diagnosis, treatment or hospital care being required in order to provide authority to render care, which the aforementioned physician in his best judgment may deem advisable. Effort shall be made to contact me before rendering treatment to the patient, but any of the above treatment will not be withheld if I cannot be reached.

I am aware of the dangers inherent in sailing, swimming and tennis and the Children's Activities programs, and hereby absolve and hold harmless the Westhampton Yacht Squadron, Ltd., its employees or members, from any liability for injury of damage not caused by negligence or culpable conduct.

I give permission for my child's picture to appear on our website or Facebook page and participate in end of year photo. □ Yes □ No

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 |
|---|---|
| | |

**2019 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 HIS OR HER 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: _____

_____

_____

***PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION.***

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

THANK YOU!