THIS AGREEMENT CONTAINS A RELEASE AND WAIVER-READ FIRST

MYC & MYC Youth Sailing Foundation Release and Waiver Agreement

In consideration of the acceptance of my registration fee and of the substantial volunteer efforts of the directors, members, employees, representatives and associated volunteers for Miami Yacht Club and MYC Youth Sailing Foundation, the undersigned hereby:

1. WAIVES AND RELEASES ANY AND ALL CLAIMS, DEMANDS OR CAUSES OF ACTION, INCLUDING THOSE OF NEGLIGENCE OR EQUIVALENT CONDUCT WHICH I MAY HAVE AGAINST THE HOST, ITS DIRECTORS, MEMBERS, EMPLOYEES, REPRESENTATIVES, ASSOCATED VOLUNTEERS, MIAMI YACHT CLUB AND THE MYC YOUTH SAILING FOUNDATION RESULTING FROM THE OPERATION OF THE MYC SAILING EVENT (hereinafter "Event") AND ALL ACTIONS RELATED THERETO.

2. Acknowledges my responsibilities in the participation in this Event, for decisions to attend and to participate in Event activities, and to make certain that my boat, equipment and crew are seaworthy for the conditions which may be encountered during participation.

3. Specially waives any statute, by incorporating its reference and citation herein, which may require such inclusion and reference in order to effect these provisions. If any provision of the agreement is not enforceable, such determination shall not affect the enforceability of the remaining provisions of this agreement. This agreement shall be construed and enforced under the laws of the State of Florida.

Sailor's Name:_____ Age:_____

_____ _____

Parent's Signature Date

MEDICAL CONSENT FORM

Only COMPLETELY FILLED IN forms will be accepted. Doublehanded skippers and crews must EACH complete and sign separate copies of this 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 (Miami Yacht Club and Miami Yacht Club Youth Sailing Foundation) 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 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 on 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.

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

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 REVERSE SIDE

MEDICAL AND EMERGENCY INFORMATION

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

ADDRESS:_____
Street/P.O. Box

_____
City *State* *Zip*

TELEPHONE _____(R) _____(B) 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		BEE STINGS/INSECT BITES	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		FOODS	
CIRCULATORY OR HEART PROBLEMS		OTHERS, IF SIGNIFICANT	
EPILEPSY			

DATE OF LAST TETANUS SHOT: _____ BLOOD TYPE: _____

CURRENT MEDICATIONS, IF ANY:_____

DETAILS: _____

_____

_____

_____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION