WAIVER OF LIABILITY/RELEASE OF RISK - INTERSCHOLASTIC SAILING ASSOCIATION (ISSA)

Sailor Name: _____ School Name: _____

WAIVER OF LIABILITY/RELEASE OF RISK - INTERSCHOLASTIC SAILING ASSOCIATION (ISSA) As the parent/guardian of the above named student, I hereby acknowledge that Sailing is an activity that has an inherent risk of damage and injury. Competitors in this event are participating entirely at their own risk. See RRS 4, Decision to Race. The ISSA and race organizers (organizing authority, race committee, host club, sponsors, or any other organization or official) will not be responsible for damage to any boat or other property or the injury to any competitor, including death, sustained as a result of participation in this event. By participating in this event, each competitor agrees to release the ISSA and race organizers form any and all liability associated with such competitor's participation in this event to the fullest extent permitted by law.

Signature: _____ Date: _____

Print Name: _____ Relation to Sailor_____

Sailor Name: _____ School Name: _____

Contact/ Chaperon/ Coach Information:
Team Contact (Traveling with team), Coach (If you will have one with you):
_____/_____

Cell Phone: (____) _____ E-Mail: _____

Emergency Contact:

Name_____ ph_____ mobile _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

The undersigned parent or guardian of a minor does hereby consent to emergency X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, or dentist under the Dental Practice Act. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgment may deem advisable. It is understood that efforts shall be made to contact the undersigned or Emergency Contact prior to rendering treatment, but treatment will not be withheld if they cannot be reached.

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Medical Problems: _____

Known Allergies: _____

Hospital Insurance Plan Name/Number: _____

SIGNATURE (Parent or Legal Guardian): _____ Date _____

PRINT NAME (Parent or Legal Guardian): _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Phone (h): _____ (w): _____ (c): _____

Father's Phone (h): _____ (w): _____ (c): _____