## The Southern Massachusetts Sailing Association Personal Health and Medical Form

Name	Date	of Birth	A	.ge	_Gender
Parent/guardian		Phone (	_)	or (	)
Home address		Town/City_			_ State
Business address		Town/Cit	у		_State
If the person named	above is not available in the	event of any en	mergency, not	tify:	
Name	Relationship_		Phone		
Name of personal ph	ysician		Phone		
reached, I hereby giv	ency, I understand every effecte my permission to the physization, anesthesia, surgery	sician selected	to secure the p	proper med	ical treatment, which
Date	Signature of parent/guar	dian			_
Medical information	past or present (please chec	:k):			
Allergies yes[] Convulsions yes[]	no[] Heart disease no[] High blood pressure no[] Diabetes	yes[] no[] yes[] no[]	Hemophilia	yes[] no [ yes[] no[	[] ]
Explanations:					
Allergies:					
	[ ] Plants yes[ ] no[ [ ] Insect bites yes[ ] no[				
	swers and give all information				
Any special equipme	ent such as orthopedic or har	ndicap devices,	glasses or con	ntacts, dent	ures? yes[] no[]
What?					
	shot:				

SM Sailing Medical Form Revised: 3/18/2007