CLEARWATER COMMUNITY SAILING CENTER
1001 GULF BOULEVARD
CLEARWATER, FLORIDA 33767
Phone: (727) 517-7776 Fax: (727) 489-2602
Email: ccsc@clearwatercommunitysailing.org

www.clearwatercommunitysailing.org

Medical Information & Consent Form

Only completely filled in forms will be accepted. Double handed skippers and crews must EACH complete and sign separate copies of this form. Please attach a copy of your health insurance card.

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 CCSC while participating in an event under the auspices of CCSC where I am unable to consent or am not present:

1. I hereby voluntarily consent to the furnishings to myself, my spouse or any child of mine such medical care and treatment by any hospital or physician (s) as the hospital or physician (s) deem necessary or advisable.
2. I authorize a representative of CCSC to grant authorization for necessary 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 CCSC 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 aforementioned physician in his best judgment may deem advisable. Effort shall be made to contact me before rendering treatment with the patient, but any of the above treatment will not be withheld if I cannot be reached.

Signature of Participant : _____ Date _____

Signature of Parent/Guardian (If a minor): _____ Date _____

IN CASE OF EMERGENCY CALL:

Name	Relationship	Phone Number

Name	Phone Number	Date of Last Exam

Carrier Name	Insurance ID Number