



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 And Emergency Information

PARTICIPANT NAME _____ SEX _____ (M) _____ (F)

ADDRESS _____

PHONE _____ (Home) _____ (Emergency Cell)

DATE OF BIRTH _____

THE PARTICIPANT AND PARENT/GUARDIAN IF A MINOR, MUST ANSWER THE FOOLOWING QUESTIONS AS ACCURATELY AND COMPLETELY AS POSSIBLE:

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:		ALLERGIES:	
ASTHMA OR OTHER RESPIRATORY		MEDICATION	
DIABETES OR HYPOGLYCEMIA		LATEX	
HEMOPHILIA, OR OTHER BLEEDING		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!**