CENTRALS ON SODUS
ANNUAL REGATTA

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. 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 the Host Club/Organization 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 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 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.

Signature of Parent/Guardian:_____ Date: _____

IN CASE OF EMERGENCY CALL:

NAME_____

RELATIONSHIP_____

PHONE NUMBER_____

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MEDICAL AND EMERGENCY INFORMATION

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

ADDRESS:_____
Street/P.O. Box

_____
City State Zip

PHONE: _____ (home) _____ (emergency cell)

DATE OF BIRTH: _____

Health Insurance Carrier: _____

Insurance ID Number: _____

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 LATEX
HEMOPHILIA, OR OTHER BLEEDING
PROBLEMS
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!

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