2017 Lightning Women Juniors and Masters North American Championship
Metedeconk River Yacht Club
Brick, NJ

MEDICAL CONSENT FORM

Only completely filled in forms will be accepted. All crew 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/GUARDIAN (printed):_____

In the event of an accident or injury to myself, my spouse or any child of mine 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 and 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 Rochester Yacht Club and its officers and members.

I hereby authorize 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 or 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 physical in his best judgement 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

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

PLEASE FILL OUT THE REVERSE SIDE

MEDICAL AND EMERGENCY INFORMATION

NAME:_____ SEX_____(M)_____(F)

ADDRESS:_____
Street/P.O. Box

_____
City *State* *Zip*

PHONE:_____(home) _____(emergency cell)

DATE OF BIRTH:_____

THE PARTICIPANT AND HIS OR HER PARENTS MUST ANSWER THE FOLLOWING QUESTIONS AS ACCURATEY 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!