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

Please print or type.

Name		Date of	Date of Birth		Sex
Name of parent/guardian			Phone_		
Home address	S		Town/City		State
Business addr	·ess		Town/City		State
If the person i	named above i	is not available in the ev	vent of any em	nergency, notif	y:
Name I		Relationship	RelationshipPhone		
Name		Relationship		Phone	
Name of person	onal physician	1		Phone	
Health/Accide	ent Insurance	Carrier			
Medical infor Asthma	mation past or yes[] no[]	r present (please check)  Heart disease		Leukemia	yes[] no[]
Allergies	yes[] no[]	High blood pressure	yes[] no[]	Cancer	=
Convulsions	yes[] no[]	Diabetes	yes[] no[]	Hemophilia	yes[] no[]
Explanations:					
Allergies:					
•		Plants yes[] no[ Insect bites yes[] no[			
		and give all information	-		nd as full participation as
		n as orthopedic or hand			
Date of last T	etanus shot:				