Participant Waiver & Parent/Guardian Consent

Must be presented to the Race Office at check-in

Event: _____ Event Dates: _____

Participant's Name: _____ Date of Birth: _____

email: _____ Phone: _____

Emergency Contact: _____ Phone: _____
(best contact in case of emergency)

I, _____ voluntarily participate in this Event and understand that the decision whether or not to participate rests solely upon myself. I understand that sailing can be a hazardous sport and agree to accept all inherent risks involved. To the fullest extent permitted by law, I hereby waive any rights I may have to sue the Columbia Gorge Racing Association, the Port of Cascade Locks, instructors, race officials, sponsors, volunteers or any other organization or official involved with this Event ("Organizers") with respect to personal injury or property damage suffered by myself as a result of my participation in this event and hereby release the Organizers from any liability for such injury or damage.

Signature: _____ Date _____

Note: A *Participant Waiver & Parent/Guardian Consent* must be completed by all members of a participating boat's crew.

PARENT OR GUARDIAN MUST COMPLETE FOR MINORS (UNDER 18 YEARS OF AGE)

I am the parent or legal guardian of, _____, a minor ("Child"). I understand that participation in this event is voluntary and the decision whether or not to participate rests solely upon the Child, myself or my designee. I understand that sailing can be a hazardous sport and on behalf of the Child, agree to accept all inherent risks involved. To the fullest extent permitted by law, I hereby waive any rights I or the Child may have to sue the Columbia Gorge Racing Association, the Port of Cascade Locks, instructors, race officials, sponsors, volunteers or any other organization, or official ("Organizers) involved with the event with respect to personal injury or property damage suffered by the Child as a result of our participation in this event and hereby release the Organizers from any liability for such injury or damage. I represent that I am authorized to represent said Child and make this agreement on his/her behalf.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (print): _____ Phone: _____

Support Adult on Site (print): _____ **Phone:** _____
(best contact in case of emergency)

Medical Consent Form

Participant (print): _____ DOB: _____

Parent or Guardian (print): _____ Phone: _____

Supervising Adult on Site (print): _____ Phone: _____

Supervising Adult on Site Relationship to Participant: _____

In the event of accident or injury to myself, my spouse or my child (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 the Supervising Adult listed above, the authority to advise and sign for 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: _____

The participants parent or guardian must fill in the following information as accurately and completely as possible:

Physician who conducted participants latest physical exam	Phone	Date of Latest Exam

Health Insurance Carrier	Insurance ID Number

CHRONIC AILMENTS:	Y/N	**ALLERGIES:**	Y/N
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 (list)	
OTHER		OTHERS, IF SIGNIFICANT	

Date of Last Tdap (Tetanus/Diphtheria/Acellular Pertussis) vaccination: _____

Current Medications and Dosage if any: _____

Other Important Details (use back if necessary): _____

_____

Thank you for taking the time to fill in this information.
We care about the health and well being of all of our participants.