Laser District 8 Grand Prix
Medical/Minor Release

Sayville Yacht Club July 10-11, 2010

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 in, on or about the premises of the SAYVILLE YACHT CLUB ("Host Club") or while participating in any activity sponsored by or under the auspices of Host Club under any circumstances where I am physically unable to consent or am not present:

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any physician, dentist or other medical professional licensed under the provisions of relevant law. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned medical professional in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

In case of emergency call:

NAME_____
RELATIONSHIP_____
PHONE NUMBER (_____)_____-_____
Physician who conducted participant's most recent physical exam:
NAME _____
EMERGENCY PHONE NUMBER (_____)_____
DATE OF LAST EXAM_____
HEALTH INSURANCE CARRIER_____
INSURANCE ID NUMBER _____
Signature of parent or guardian

_____

Date _____

MEDICAL AND EMERGENCY INFORMATION

Name of Participant _____ SEX (M) _____ (F) _____
Address_____
Street / P.O. Box_____
City_____
State/Province / Zip / Postal Code / Country_____
Phones (B) _____ (R) _____
Mobile Phone _____
Date of Birth _____

PLEASE answer the following questions as accurately and completely as possible:
Please check those that apply: (Provide details below, as appropriate):

π ASTHMA, OR OTHER RESPIRATORY PROBLEMS
π BEE STINGS/INSECT BITES
π CIRCULATORY OR HEART PROBLEMS
π CHRONIC ALLERGIES
π DIABETES OR HYPOGLYCEMIA
π EPILEPSY
π FOOD ALERGIES
π HEMOPHILIA, OR OTHER BLEEDING PROBLEMS
π OTHERS, IF SIGNIFICANT (describe below)
π MEDICATION
DETAILS / COMMENTS:
_____
_____
_____
_____
_____

DATE OF LAST TETANUS SHOT: _____BLOOD TYPE: _____
THIS FORM MUST BE COMPLETED AND SUBMITTED BY OR FOR ALL PARTICIPANTS