Silver Gate Yacht Club

Junior Sailing

Medical Consent

Each participant must complete and sign a copy of this form. Please fill it out completely. Incomplete forms will not be accepted. **This Medical Consent Form shall remain effective until revoked in writing. Please print clearly and legibly!**

NAME OF PARTICIPANT: _____ DATE OF BIRTH: _____

NAME OF PARENT OR GUARDIAN (**if under 18**

In the event of accident or injury to myself, or any child of mine (specifically including my child if named above as the "Participant") or in the event of illness of myself, or any child of mine while in, on or about the premises of the Silver Gate Yacht Club Foundation Junior Sailing Program [hereinafter "SGYC JS"] or while participating in any activity sponsored by or under the auspices of SGYC JS under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.
2. I authorize the General Manager, Assistant General Manager, Director, coaches, instructors, volunteers or any officer or member of SGYC JS to consent to such medical care, attention or treatment.
3. I agree to pay all costs of such medical care, attention or treatment and to hold free and harmless of and from any and all liability for such cost SGYC JS along with the officers, directors, volunteers and members of SGYC JS.

I, the undersigned, do hereby authorize and consent to any emergency care, included but not limited to: x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff of a medical facility. 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 physician in the exercise of his 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.

Signature:
Parent/Guardian Signature (**if under 18**): Date:

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL AND EMERGENCY INFORMATION

Participant'sname:_____

Parent/legal guardian name_____

Address: _____

City/State/Zip: _____

Telephone (home) _____(Emergency cell) _____Date of Birth: _____

CURRENT ATTENDING PHYSICIAN:

NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER:
INSURANCE ID NUMBER:

THE PARTICIPANT AND/OR THEIR PARENT(S) MUST RESPOND TO 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(s) (please list below)	
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		Other	

DATE OF LAST TETANUS/ DIPTHERIA/ TOXOID / T/d or Tdap SHOT:

CURRENT MEDICATIONS AND DOSAGE IF ANY: _____

COMMENTS / NOTIFICATIONS:

_____

_____

_____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION