

**MEDICAL CONSENT FORM**

*Only COMPLETELY FILLED IN forms will be accepted.*

**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 below as the "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 United States Sailing Center (USSC), adba Pacific Coast Sailing Foundation (PCSF), or while participating in any activity sponsored by or under the auspices of the USSC or PCSF under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse 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 any officer or member of the USSC or PCSF to consent to such medical care, attention or treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost the USSC, PCSF, and the United States Sailing Association and its officers and members thereof.

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 member of the medical staff or of a dentist licensed under the provisions of the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. 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.

**IN CASE OF EMERGENCY CALL:**

NAME	RELATIONSHIP	PHONE NUMBER

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:**

NAME	PHONE NUMBER	DATE OF LAST EXAM

Insurance Carrier	Policy Number	Policy Holder's Name	Policy Holder's Date of Birth
Insurance Carrier Address	Insurance Carrier Phone #	Policy Holder's Relation to Participant	Policy Holder Phone #

**PLEASE FILL OUT THE REVERSE SIDE**

## MEDICAL AND EMERGENCY INFORMATION

NAME: \_\_\_\_\_ SEX \_\_\_\_ (M) \_\_\_\_ (F)

ADDRESS: \_\_\_\_\_  
*Street/P.O. Box*

\_\_\_\_\_ *City* *State* *Zip*

TELEPHONE \_\_\_\_\_ (R) \_\_\_\_\_ (B) DATE OF BIRTH: \_\_\_\_\_

**THE PARTICIPANT AND HIS OR HER PARENTS 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
DIABETES OR HYPOGLYCEMIA	BEE STINGS/INSECT BITES
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	FOODS
CIRCULATORY OR HEART PROBLEMS	OTHERS, IF SIGNIFICANT
EPILEPSY	

DETAILS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_ BLOOD TYPE: \_\_\_\_\_

CURRENT MEDICATIONS IF ANY: \_\_\_\_\_

DOES THE ABOVE NAMED INDIVIDUAL HAVE ANY MEDICAL CONDITION THAT MAY AFFECT PARTICIPATION IN ACTIVITIES AT THE USSC? IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION**