



US SAILING
 PO Box 1260
 Portsmouth, RI 02871
 Bus: (401) 683-0800
 Fax: (401) 683-0840

MEDICAL CONSENT FORM

Each participant must complete and sign a copy of this form. Please fill it out completely. Incomplete forms will not be accepted. Please bring this completed form with you to your first day of class.

NAME OF PARTICIPANT: _____

NAME OF PARENT OR GUARDIAN (if under 18) _____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child if named above 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 Sail Training Foundation or while participating in any activity sponsored by or under the auspices of the Sturgeon Bay Yacht Club 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 the Sailing Instructor, General Manager, Assistant General Manager or any officer or member of the Sail Training Foundation 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 the Sail Training Foundation, the Sturgeon Bay Yacht Club, their respective officers and directors and any personnel engaged or volunteering to help conduct this course.

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 by the State of Wisconsin or 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 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

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

PLEASE FILL OUT THE REVERSE SIDE



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MEDICAL AND EMERGENCY INFORMATION

Participant's name: _____ Male ____ Female ____

Address: _____

City/State/Zip: _____

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

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 (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/ DIPHTHERIA/ TOXOID SHOT: _____

CURRENT MEDICATIONS AND DOSAGE IF ANY: _____

DETAILS: _____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION
If any of the above mentioned information changes before or during the sailing course,
please submit in writing all pertinent information to your sailing instructor.

 PLEASE BRING THIS FORM WITH
 YOU TO THE FIRST DAY OF
 YOUR SAILING COURSE.



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