



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

**MEDICAL CONSENT FORM**

Skippers and crews must *each* complete and sign separate copies of this form. Please fill it out completely. Incomplete forms will not be accepted.

NAME OF PARTICIPANT: \_\_\_\_\_

NAME OF PARENT OR GUARDIAN: \_\_\_\_\_

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 Davis Island Yacht Club or while participating in any activity sponsored by or under the auspices of the Davis Island 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 General Manager, Assistant General Manager or any officer or member of the Davis Island Yacht Club 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 indemnify and hold free and harmless of and from any and all liability for such cost the Davis Island Yacht Club, the United States Sailing Association and the officers and members of each.

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 Florida or of any hospital holding a current operating certificate issued by the State Department of Health and Family Services. 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.

Parent/Guardian Signature: \_\_\_\_\_ 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**

## MEDICAL AND EMERGENCY INFORMATION

Competitor's name: \_\_\_\_\_ Male \_\_\_\_ or Female \_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone \_\_\_\_\_ (home) \_\_\_\_\_ (cell) Date of Birth: \_\_\_\_\_

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

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

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

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

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

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