

**CYC Junior Division
PO Box 456
Chaumont, NY 13622**

MEDICAL AND EMERGENCY INFORMATION

Participant Name _____ Sex ____ (M) ____ (F)

Address _____

Street/ PO Box

City

State

Zip

Parent/Guardian Telephone _____ (Home) _____ (Work) _____ (Cell)

Email Address _____ Date of Birth _____

THE PARTICIAPANT AND HIS OR HER PARENTS MUST RESPOND TO THE FOLLOWING QUESTIONS AS ACCURATELY AND COMPLETELY AS POSSIBLE:

Please check those that apply and provide necessary details below:

CHRONIC AILMENTS		ALLERGIES	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS	<input type="checkbox"/>	MEDICATION	<input type="checkbox"/>
DIABETES OR HYPOGLYCEMIA	<input type="checkbox"/>	BEE STINGS/INSECT BITES	<input type="checkbox"/>
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	<input type="checkbox"/>	FOODS	<input type="checkbox"/>
CIRCULATORY OR HEART PROBLEMS	<input type="checkbox"/>	OTHER, IF SIGNIFICANT (describe below)	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>		<input type="checkbox"/>

Date of last tetanus shot: _____ Blood Type _____

Current Medication if any: _____

Details:

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION

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MEDICAL CONSENT FORM

PLEASE PRINT ALL INFORMATION

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 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 Yacht Club or while participating in any activity sponsored by or under the auspices of said Club under circumstance 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 deem necessary or advisable.
2. I authorize any officer or member of the Yacht Club 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 Yacht Club and the United State 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

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER