

MEDICAL CONSENT FORM

2004 USODA ATLANTIC COAST CHAMPIONSHIP

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 above as "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 FISHING BAY YACHT CLUB ("Host Club") or while participating in any activity sponsored by or under the auspices of Host Club under any circumstances where I am physically unable to consent or am not present:

1.1 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, dentist or other medical professional as such hospital, physician, dentist or other medical professional may deem necessary or advisable.

2.1 authorize any officer, volunteer or member of FISHING BAY YACHT CLUB to consent to such medical care, attention or treatment.

3.1 agree to pay the reasonable cost of such medical care, attention or treatment and to reimburse FISHING BAY YACHT CLUB, the United States Optimist Dinghy Association, and their respective officers, employees, contractors, volunteers or members, for any expenses any of them may incur in connection with such medical care, attention or treatment.

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 physician, dentist or other medical professional licensed under the provisions of relevant law. 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 medical professional in the exercise of his/her 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: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician who conducted participant's Most Recent Physical Exam:

NAME: \_\_\_\_\_

EMERGENCY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DATE OF LAST EXAM: \_\_\_\_\_

HEALTH INSURANCE CARRIER: \_\_\_\_\_

INSURANCE ID NUMBER:

Signature of parent or guardian:

\_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL AND EMERGENCY INFORMATION**

Name of Participant: \_\_\_\_\_ SEX: (M) \_\_\_\_\_ (F) \_\_\_\_\_

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

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

City: : \_\_\_\_\_

State/Province / Zip / Postal Code / Country: \_\_\_\_\_

Phones: (B) \_\_\_\_\_ (R) \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PLEASE answer the following questions as accurately and completely as possible:

Please check those that apply: (Provide details below, as appropriate):

- ASTHMA, OR OTHER RESPIRATORY PROBLEMS
- BEE STINGS/INSECT BITES
- CIRCULATORY OR HEART PROBLEMS
- CHRONIC ALLERGIES
- DIABETES OR HYPOGLYCEMIA
- EPILEPSY
- FOODS
- HEMOPHILIA, OR OTHER BLEEDING PROBLEMS
- OTHERS, IF SIGNIFICANT (describe below)
- MEDICATION

DETAILS / COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**THIS FORM MUST BE COMPLETED AND SUBMITTED BY OR FOR ALL PARTICIPANTS**

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Host Club Use Only:

Reviewed by:

Date Complete: