

MEDICAL CONSENT FORM & EMERGENCY INFORMATION

YOUTH WORLD QUALIFIER January 16-18, 2010

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 CLEARWATER 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:

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