CLARK MILLS REGATTA – SATURDAY 18 MARCH 2017
MEDICAL CONSENT & EMERGENCY INFORMATION FORM Page 1 of 2

Name of Participant (Print) _____

Name of Parent or Guardian (Print) _____

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 or about the premises of the CLEARWATER YACHT CLUB and CLEARWATER COMMUNITY SAILING CENTER or while participating in any activity sponsored by or under the auspices of Host Club under any circumstances while 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 absence 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: CELL _____ **OFFICE** _____ **HOME** _____

Physician who conducted Participants most recent physical exam:

NAME _____ **PHONE:** _____ **LAST EXAM** _____

HEALTH INSURANCE CARRIER: _____

INSURANCE I.D. NUMBERS _____

SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____

CLARK MILLS REGATTA – SATURDAY 18 MARCH 2017
MEDICAL CONSENT & EMERGENCY INFORMATION FORM Page 2 of 2

NAME of Participant (Print) _____ **SEX (M)** _____ **(F)**_____

Address: _____

City_____**State** _____

_____

Postal Code_____ **Country:** _____

PHONE: Cell _____**H**_____ **B**_____

DATE OF BIRTH: _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE
CHECK ALL THAT APPLY & INSERT DETAILS BELOW IF APPROPRIATE

_____ **ASTHMA OR OTHER RESPIRATORY PROBLEMS**

_____ **ALLERGY TO BEE STINGS / INSPECT BITES**

_____ **CIRCULATORY OR HEART PROBLEMS**

_____ **CHRONIC ALLERGIES**

_____ **DIABETES OR HYPOGLYCEMIA**

_____ **EPILEPSY**

_____ **FOOD ALLERGIES**

_____ **HEMOPHILIA OR OTHER BLEEDING PROBLEMS**

_____ **OTHER SIGNIFICANT**

DETAILS: _____

_____

MEDICATIONS USED: _____

_____