

MEDICAL CONSENT FORM

Each participant must complete and sign a copy of this form. Please fill it out completely. Incomplete forms will not be accepted. *Bring this form to the regatta filled out and signed.*

NAME OF PARTICIPANT: _____

NAME OF PARENT OR GUARDIAN (if applicable) _____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child if 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 Shrewsbury Sailing and Yacht Club or while participating in any activity sponsored by or under the auspices of the Shrewsbury Sailing and 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 Shrewsbury Sailing and 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 hold free and harmless of and from any and all liability for such cost the Shrewsbury Sailing and Yacht Club and the officers and members.

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 New Jersey or 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.

Signature: _____

Parent/Guardian Signature (if applicable): _____ 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) _____ (Emergency cell) Date of Birth: _____

THE PARTICIPANT AND/OR THEIR 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 (please list below) |
| DIABETES OR HYPOGLYCEMIA | LATEX |
| HEMOPHILIA, OR OTHER BLEEDING PROBLEMS | BEE STINGS/INSECT BITES |
| CIRCULATORY OR HEART PROBLEMS | IF YES, DO YOU CARRY AN EPIPEN? |
| EPILEPSY/ SEIZURE | FOODS |
| OTHER | OTHER |

DATE OF LAST TETANUS/ DIPHTHERIA/ TOXOID SHOT: _____

CURRENT MEDICATIONS AND DOSAGE IF ANY: _____

DETAILS: _____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION
If any of the above mentioned information changes before or during the event,
please submit in writing all pertinent information to the regatta chairperson.