



# The Hull Yacht Club

## Medical Consent and Emergency Contact Form

Only COMPLETELY FILLED IN forms will be accepted. Double handed skippers and crews must EACH complete and sign separate copies of this form.

NAME OF PARTICIPANT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**PARENT INFO:**

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone 1: \_\_\_\_\_ Cell/Work Phone 2: \_\_\_\_\_

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 the Yacht Club under circumstances where I am physically unable to consent or am not present:

- 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.
- I authorize any officer or member of the Yacht Club to consent to such medical care, attention, or treatment.
- 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 States 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

PHYSICIANS:			
	NAME	PHONE NUMBER	DATE OF LAST EXAM
PHYSICIAN			
DENTIST			

PHYSICIANS:	
HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

Weight		Height	
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Any health problems/learning differences we should be aware of? \_\_\_\_\_  
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 \_\_\_\_\_

Is your child taking any medications? Please specify \_\_\_\_\_  
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Any allergies? \_\_\_\_\_  
 \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

Date \_\_\_\_\_

Printed Name: \_\_\_\_\_