

MEDICAL CONSENT FORM

Only COMPLETELY FILLED IN forms will be accepted.

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 below 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 St. Petersburg Sailing Center (SPSC), St. Petersburg Yacht Club (SPYC), University of South Florida St. Petersburg (USFSP), or while participating in any activity sponsored by or under the auspices of the SPSC, SPYC, or USFSP, 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 any officer or member of the SPSC, SPYC, or USFSP to consent to such medical care, attention or treatment.
3. 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 SPSC, SPYC, and USFSP and its officers and members thereof.

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or urgical 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

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	DATE	PHONE

INSURANCE CARRIER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S DOB
INSURANCE ADDRESS	INSURANCE PHONE	POLICY HOLDER'S RELATION TO PARTICIPANT	POLICY HOLDER PHONE

MEDICAL AND EMERGENCY INFORMATION

NAME: _____ SEX _____ (M) _____ (F)

ADDRESS: _____

STREET: _____

CITY ST ZIP: _____

TELEPHONE: _____ TYPE: _____ DATE OF BIRTH: _____

THE PARTICIPANT AND HIS OR HER PARENTS 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	
DIABETES OR HYPOGLYCEMIA		BEE STING / INSECT BITES	
HEMOPHILIA OR OTHER BLEEDING PROBLEMS		FOODS	
CIRCULATORY OR HEART PROBLEMS		OTHERS, IF SIGNIFICANT	
EPILEPSY			

DETAILS: _____

DATE OF LAST TETANUS SHOT: _____ BLOOD TYPE: _____

CURRENT MEDICATIONS IF ANY: _____

DOES THE ABOVE NAMED INDIVIDUAL HAVE ANY MEDICAL CONDITION THAT MAY AFFECT PARTICIPATION IN ACTIVITIES? _____ IF YES, PLEASE EXPLAIN: _____

PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION