

Henderson Harbor Water Sports Programs

Medical Information & Release Form

This form must be completed and signed by the Parent(s)/Legal Guardian(s) of the student before student can participate in the program. In case of student requiring professional medical attention, this form will accompany the student to the hospital.

Please use 1 form for each child being registered.

Last Name: _____ First Name: _____

DOB: _____ Weight: _____ Height: _____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

#1 Name: _____ Relationship: _____

Home/cell phone: _____ Work phone: _____

#2 Name: _____ Relationship: _____

Home/cell phone: _____ Work phone: _____

MEDICAL INFORMATION

Do you currently have a history of, or do you currently have any physical limitations that might prevent you from fully participating in this course? Yes No

If yes, please check those that apply or specify if other.

Chronic Ailments:

Asthma or other respiratory problems

Circulatory or heart problems

Diabetes or Hypoglycemia

Epilepsy

Hemophilia, or other bleeding problems

Other: _____

Allergies:

Insect bites

Bee stings

Foods please list _____

Please complete both pages of this form

Are you currently taking any medications? Yes No

If yes, please list _____

Do you have a learning challenge? Yes No

If yes, please specify: _____

Blood Type (optional) _____ Date of Last Tetanus shot _____

Have you received all standard childhood vaccines? Yes No

If no, please give explanation, and list which vaccines have not been received _____

Family Physician Name _____ Phone _____

Date of last physical exam _____

Insurance Carrier _____ Insurance ID number _____

Liability & Medical Release: I (we) the undersigned student, or as parent, parents, or guardian of _____, a minor, understand that participation in this program is entirely at our/their own risk and that neither the Henderson Harbor Water Sports Program, Inc. Officers, Board of Directors, volunteers, instructors, Henderson Harbor Yacht Club, chaperones, sponsors, nor the organizing bodies or committees, or individuals appointed or volunteering accept any liability for damage - material or personal - suffered during this program, and do hereby authorize and consent to any x-ray, examination, anesthetic, medical, or surgical diagnosis rendered under the provisions of the Medicine Practice Act, or a dentist licensed under the provision of the Dental Practice Act, or on the staff of any acute general hospital, holding a current license to operate a hospital from the State of New York Department of Health, or from any other state, or from Canada. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but it is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgement may deem advisable. It is understood that all 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 can not be reached.

Signature of adult student, or parent, or guardian: _____

Relationship to student: _____ Date: _____

