SEQUOIA YACHT CLUB

Medical & Emergency Information

This form must be completed and signed by or your parents/guardian (if you are a minor) and turned in prior to the start of your course.

Course		**Date**		**Accepted**	
Participates Name		Birth Date		Sex	
Address					
	No	Street	Apt No	City	Zip

Do you have a history of or do you currently have, any physical limitation that might prevent you from fully participation in this course?	
If yes, please specify missing or injured bodily parts, weakness, eyeglasses, contacts, hearing aids, etc.	
Do you have any learning disability that might prevent you from fully participation in this course?	
If yes, please specify	

Please check that apply and provide necessary information on reverse side of this form.

CHRONIC AILMENTS:		**ALLERGIES**	
• Asthma, or other respiratory problems		• Insect bites	
• Circulatory or heart problems		• Bee stings	
• Diabetes or hypoglycemia		• Food	
• Epilepsy		• Drugs	
• Hemophilia, or other bleeding problems		• Others, if significant	

Current medication or pertinent information					
Blood Type		Date of last tetanus shot		Date of most recent physical examination	
FAMILY PHYSICIAN NAME		Phone w/Area Code			
Where are your medical records kept?					
Insurance Carrier		Insurance ID #			

Who should be notified in case of emergency?

Name				**Relation**		
Phone w/AC		**Work**		**Home**		**Cell**
Name				**Relation**		
Phone w/AC		**Work**		**Home**		**Cell**

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 Education Law and/or Public Health Law of the State of California and on the staff of any hospital holding a current operation certificate issued by the department of Health of the State of California. 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/her best judgment may deem advisable. It is understood that efforts shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

Signed	**Applicant, or Parent/Guardian (if minor)**	**Date**