FLORIDA REGISTRATON# CH20470
A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE (800-435-7352) WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE.

We Teach Kids Sailing!

2019 PROGRAM – VOLUNTEER
MEDICAL CONSENT & EMERGENCY INFORMATION

VOLUNTEER NAME ____________________________________ DATE OF BIRTH ________________

STREET ADDRESS ______________________________________ GENDER (M) __ (F) __

CITY ____ STATE ______ ZIP CODE ____________

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named above as "Volunteer") or in the event of illness of myself, my spouse or any child of mine while in or about the premises of TSS Youth Sailing Inc., or while participating in any activity sponsored by or under the auspices of TSS Youth Sailing Inc., under any circumstances while I am physically unable to consent or am not present,

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 physician, dentist or other medical professional licensed under the provisions of relevant law. It is understood that this authorization is given in absence of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned medical professional in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the contact cannot be reached.

In case of emergency call:

NAME ____ RELATIONSHIP __________________________

PHONE: CELL ____________________ OFFICE ____________________ HOME ____________________

Physician who conducted Volunteer's most recent physical exam:

PHYSICIAN NAME ___________________________________ PHYSICIAN PHONE ____________________

DATE OF MOST RECENT PHYSICAL EXAM _______________

HEALTH INSURANCE CARRIER: ____

INSURANCE GROUP# ____________________ INSURANCE ID# ____________________

If Volunteer <u>is not a minor</u>:
VOLUNTEER SIGNATURE ____________________________________ DATE ______________

If Volunteer <u>is a minor</u>:
PARENT/GUARDIAN NAME (PRINT) ____________________________________

PARENT/GUARDIAN SIGNATURE ____________________________________ DATE ______________

Please continue on Page 2

2019 PROGRAM – YOUTH SAILOR
MEDICAL CONSENT & EMERGENCY INFORMATION

VOLUNTEER NAME ____

If the volunteer is less than 7-years old or requires medication or has a medical or other condition that may affect behavior or performance, please disclose it. A Volunteer's age, ability and/or special need will not necessarily deter a Volunteer's participation in the program.

PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE.

CHECK ALL THAT APPLY & INSERT DETAILS BELOW IF APPROPRIATE.

_____ ASTHMA OR OTHER RESPIRATORY PROBLEMS

_____ ALLERGY TO BEE STINGS / INSECT BITES

_____ CIRCULATORY OR HEART PROBLEMS

_____ CHRONIC ALLERGIES

_____ DIABETES OR HYPOGLYCEMIA

_____ EPILEPSY

_____ FOOD ALLERGIES

_____ HEMOPHILIA OR OTHER BLEEDING PROBLEMS

_____ OTHER SIGNIFICANT PROBLEMS

DETAILS:

MEDICATIONS: