



FLORIDA REGISTRATION# 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 RECOMMEND-
ATION BY THE STATE.

We Teach Kids Sailing!

2019 PROGRAM – YOUTH SAILOR MEDICAL CONSENT & EMERGENCY INFORMATION

STUDENT 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 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 student's most recent physical exam:

PHYSICIAN NAME _____ PHYSICIAN PHONE _____

DATE OF MOST RECENT PHYSICAL EXAM _____

HEALTH INSURANCE CARRIER: _____

INSURANCE GROUP# _____ INSURANCE ID# _____

If student is not a minor:

STUDENT SIGNATURE _____ DATE _____

If student is a minor:

PARENT/GUARDIAN NAME (PRINT) _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Please continue on Page 2

**2019 PROGRAM – YOUTH SAILOR
MEDICAL CONSENT & EMERGENCY INFORMATION**

STUDENT NAME _____

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: