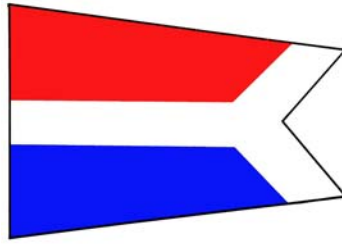

HALIFAX YOUTH SAILING
MEDICAL & EMERGENCY INFORMATION

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

Name ______ ______ ______ ______ ______ ______ ______ _ Birth date ______ ______ Sex ______

Address ______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______
No. Street City State Zip

Do you 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 specify missing or injured bodily parts, weakness, eyeglasses, contacts, hearing aids, etc. ______ ______ ______ ______ ______ ______ ______ ______
______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Do you have any learning disability that might prevent you from fully participating in this course?
______Yes ______No If yes, please specify. ______ ______ ______ ______ ______ ______ ______

Please check ( ) those that apply and provide necessary information on reverse side of this form

Chronic Ailments:
- Asthma, or other respiratory problems ______
- Circulatory or heart problems ______
- Diabetes or hypoglycemia ______
- Epilepsy ______
- Hemophilia, or other bleeding problems ______

Allergies :
- Insect bites ______
- Bee stings ______
- Foods ______
- Drugs ______
- Others, if significant ______

Current medications or pertinent information ______ ______ ______ ______ ______ ______ ______ ___

Blood type ______ ______ Date of last tetanus shot ______ ______ ______

Family physician name ______ ______ ______ ______ ______ ______ Phone ______ ______ ______

Date of most recent physical examination ______ ______ ______ ______

Where are your medical records kept? ______ ______ ______ ______ ______ ______ ______ ______ __

Insurance Carrier ______ ______ ______ ______ ______ ______ ______ Insurance ID # ______ ____

Who should be notified in case of emergency?

Name ______ ______ ______ ______ ______ ______ ______ Relation ______ ______ ______

Phone ______ ______ ______ ______ (B) ______ ______ ______ ______ (R)

Name ______ ______ ______ ______ ______ ______ ______ Relation ______ ______ ______

Phone ______ ______ ______ ______ (B) ______ ______ ______ ______ (R)

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 ________________________ and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of ______________________ . 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 effort 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.

Signature ______ ______ ______ ______ ______ ______ ______ ______ Date ______ ______ ______
Applicant, or Parent/Guardian (if a minor)

Rev. 2010-1