

MEDICAL AND EMERGENCY INFORMATION

NAME: _____ SEX ___ (M) ___ (F)

ADDRESS: _____

Street / P.O. Box _____ City _____ Zip _____
 TELEPHONE _____ (H) _____ (W) D.O.B ___/___/___ Age _____

PHYSICAL HANDICAPS: (Please specify injured body parts, weakness, eyeglasses, contacts, hearing aids, etc.)

Please check (X) those that apply: (provide necessary details on reverse of this sheet.)

CHRONIC AILMENTS:	ALLERGIES:
ASTHMA, OR OTHER RESPIRATORY PROBLEMS	MEDICATION
DIABETES OR HYPOGLYCEMIA	BEE STINGS/INSECT BITES
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	FOODS
CIRCULATORY OR HEART PROBLEMS	OTHER, IF SIGNIFICANT
EPILEPSY	

CURRENT MEDICATIONS, IF ANY: _____

PHYSICIAN'S NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

CONSENT FOR MEDICAL TREATMENT (MINOR)

As parent or legal guardian of the above-named participant, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

SIGNATURE: _____ DATE: _____

WAIVER OF LIABILITY:

I, the parent/guardian of the participant agree that I and the participant will release, discharge and/or otherwise indemnify Sail Martha's Vineyard, its affiliated personnel, including owners of the boats and facilities used for the Program, against any claims by or on behalf of the participant as a result of the participants activities in the program and/or while being transported to or from the same, which transportation I hereby authorize.

SIGNATURE: _____ DATE: _____

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

SIGNATURE of PARENT: _____ DATE: _____

Sail MV complies with regulations of the Massachusetts Department of Public Health and is licensed by the local Board of Health.