

## MEDICAL AND EMERGENCY INFORMATION

NAME: \_\_\_\_\_ SEX \_\_\_ (M) \_\_\_ (F)

ADDRESS: \_\_\_\_\_

TELEPHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W) City \_\_\_\_\_ Zip \_\_\_\_\_ D.O.B \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_\_\_

PHYSICAL HANDICAPS: (Please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, ect.) \_\_\_\_\_

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	

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

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: \_\_\_\_\_