



OFFICIAL ENTRY FORM
School's Out Regatta
May 23-24, 2009

Print Sailor's Name _____ Date of Birth _____ Sex M F

Chronic Ailments:

Asthma or other respiratory problems _____ Diabetes or Hypoglycemia _____
 Hemophilia other bleeding problems _____ Circulatory or other Heart Problems _____ Epilepsy _____

Allergies:

Bee Stings or Insect Bites _____ Foods _____ Medication _____ Other, if significant _____
 Current Medication if any _____

Date of last Tetanus Shot: _____ Blood type: _____

Any medical conditions that would be important to be aware of in the event of an emergency:

Health Insurance:

(Name of Insured) _____ (Policy Number) _____

Preferred Personal or Family Physician (s)

(Name) _____ (Phone) _____

(Name) _____ (Phone) _____

Persons to call in the event of an emergency:

(Name/Relationship) _____ (Phone) _____

Parent or Guardian Emergency Treatment Authorization:

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named above as the "Sailor") or in the event of illness of myself, my spouse or any child of mine while in, on or about the premises of the Davis Island Yacht Club or while participating in any activity sponsored by or under the auspices of the Davis Island Yacht Club under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.
2. I authorize any officer or member of the Davis Island Yacht Club to consent to such medical care, attention or treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost the Davis Island Yacht Club and its officers and members thereof.

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 State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. 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 best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Parent/Guardian (Print) _____ Telephone _____

Parent/Guardian (Sign) _____ Date _____