



Davis Island Youth Sailing Foundation
Summer Sailing Program 2011

Enter Session Number _____ and Circle (Opti or 420)

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, _____, the undersigned parent/guardian of _____, a minor child, do hereby consent to any emergency X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is determined advisable by, and is rendered by or under the general or special supervision of any physician and/or surgeon licensed by a recognized, state approving licensing authority.

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 on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforesaid agent(s) in the exercise of his/her best judgment may deem advisable; and neither said agent(s) nor any individual or organization involved assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the laws and statutes of the State of Florida and is to be considered effective in any state or other location where the child is participating in DIYSF sponsored or approved activity.

WAIVER OF LIABILITY OR RELEASE

I agree to indemnify Davis Island Youth Sailing Foundation, Inc. and the Davis Island Yacht Club, and save it harmless from suits, actions, damages, liability, and expense in connection with loss of life, bodily or personal injury or property damage and attorney's fees and costs arising from or out of any occurrence in, upon or at the premises of the DIYSF and DIYC, its directors, officers, agents, contractors, servants, invitees, licensees, or concessionaires. I am fully cognizant of the risks of sailing and I understand and agree that DIYSF and DIYC, on-shore and offshore facilities, including hoists, launching ramps, docks, pool and mooring shall be used solely at my own risk.

Signature of Parent or Legal Guardian

Date

Child's Name: _____ Child's Age: _____ Date of Birth: _____

Doctor: _____ Dr. Telephone: _____

Dentist: _____ Dent. Telephone: _____

Emergency Contact (other than parent): _____

Telephone: _____

Existing Medical Problems/Conditions: _____

Known Allergies: _____

Learning Disabilities: _____

Medical Insurance Plan (provide copy of card)

Plan Name: _____

Plan Number: _____

Plan Address: _____

Mother's Name: _____

Home Phone: _____ Work: _____ Cell: _____

Father's Name: _____

Home Phone: _____ Work: _____ Cell: _____