

**Stone Horse Yacht Club
Sailing and Swimming School**

2 Harbor Road, Harwich Port, MA 02646
508.432.0868



Medical Consent Form

Name of Participant: _____ DOB _____ Age: _____ Gender: _____

Name of Parent or Guardian: _____ Telephone: H) _____

Address: _____ W) _____

_____ Cell) _____

Business _____

Address: _____

If the person named above is not available in an emergency notify:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Medical information, check all that apply:

Asthma ___ Allergies ___ Convulsions (epilepsy) ___ Heart Disease ___ High Blood Pressure ___

Diabetes ___ Leukemia ___ Cancer ___ Hemophilia ___ OTHER _____

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

1. I hereby voluntarily consent to the furnishing of 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 Stone Horse Yacht Club, or any other event volunteer, 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 Stone Horse Yacht Club, the Laser Class Association of North America and its officers and members thereof, and the United States Sailing Association 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 Massachusetts law or 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/her best judgment may deem advisable. It is understood that every effort will 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.

Insurance Carrier and Policy #: _____

Specific Allergies or other medication information: _____

Signature of Parent / Guardian: _____ Date: _____