Emergency Medical Authorization
Berlin Yacht Club

Sailor's Information:

Sailor's Name _____ Sex M F
Date of Birth _____ Age at Camp _____
Home Address _____ Home Phone _____
_____ E-mail _____

Legal Guardian(s):

Both Parents One Parent Other

Name and Address of Legal Guardian(s) _____
_____
Telephone _____ Cell Phone _____
Father's Name _____
Address (If Different) _____
Telephone _____ Cell Phone _____
Mother's Name _____
Address (If Different) _____
Telephone _____ Cell Phone _____
Emergency Contact: _____ Relationship _____
_____
Telephone _____ Cell Phone _____

Medical Information:

(Disclosure of the following information is voluntary, but helpful in providing medical care if necessary, use the back of the form if additional space is needed)

Yes No Does your child have any allergies? If yes, please describe. _____
_____
Recommended treatment for severe reactions. _____
_____

Yes No Is you child taking any prescribed medication regularly? If yes, please list below.
_____

Yes No Is you child allergic to any prescribed and/or over the counter medication? If yes, please list below. _____
_____

Yes No Does your child have any respiratory problems? If yes, please describe. _____
_____

Yes No Has your child ever suffered a head injury severe enough to see a doctor? _____
If yes, please describe. _____

Yes No Does your child wear contact lenses? Type of lenses Hard or Soft. (circle one)

Yes No Does your child have any medical problems or history of injury that would be important for us to know? _____
_____

Yes No Does your child have any physical disabilities that would be important for us to know?

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Name of Child _____

Emergency Care Information:

Preferred Physician _____

_____

Phone _____ Fax _____

Preferred Dentist _____

_____

Phone _____ Fax _____

Preferred Hospital _____
Location _____ Phone _____

Consent:

In the event attempts to contact me have been unsuccessful on behalf of my child, _____, I give my consent for Berlin Yacht Club to contact any medical provider and to obtain any medical treatment deemed necessary by the physician or dentist in charge, and also for the transfer of the child to the hospital most reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists are obtained in concurrence.

In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all medical personnel that interact with my child. I agree to be responsible for all medical expenses relating to my child's care, and I authorize Berlin Yacht Club to provide my medical insurance information to any or all medical providers at the time the services are requested.

Parent / Guardian Signature _____ Date _____

Student Signature _____ Date _____
(if 18 years of age or older)

Medical Insurance Provider _____

Policy Number _____