Boca Ciega YACHT CLUB

Date _____/_____/_____

Youth Sailing Permission Form

Name _____ Age _____

Address _____ Date of Birth _____

_____

Parent(s) _____ Home Phone _____

or Please Print Daytime Phone _____

Guardian(s) _____ Emergency Phone _____

Please Print Cell Phone _____

Are you a club member? _____ Sponsor _____

In consideration of being permitted to participate in the Sailing School, sponsored by Boca Ciega Yacht Club of Gulfport, and being fully knowledgeable of the risks in any sport, I do hereby agree to indemnify and hold harmless the aforementioned sponsors, its officers, as well as members in the Boca Ciega Yacht Club, in the claims suit, actions, expenses, or other liabilities which may directly or indirectly arise from my child's participation in the sailing activities of the Sailing School. I also give permission for my child to receive any first aid/medical attention deemed necessary by Boca Ciega Yacht Club teaching staff should an accident occur during his/her participation in the program.

Parent(s)

or _____

Signature

Guardian(s)

_____

Signature

Boca Ciega YACHT CLUB

Personal Health and Medical Record

I give permission for full participation in BCYC programs, subject to limitations noted herein. **In case of emergency,** I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date ____/_____/_____ Parent/Guardian Signature _____

To be filled out by parent, guardian or adult participant.

IDENTIFICATION

Name_____ Date of birth_____/_____/_____

Age____ Sex____ Height _____ Weight _____ Eye color _____ Hair color _____

If person named in **above Permission Form** is not available in the event of an emergency, notify:

Name_____

Relationship_____ Telephone_____

Name_____

Relationship_____ Telephone_____

Name of personal physician_____

Telephone_____

Personal health/accident insurance carrier_____

Policy No._____

Check all items that apply, **past or present,** to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No

Explain: _____

_____

GENERAL INFORMATION:

ADHD (Attention-Deficit Hyperactivity Disorder)	Yes	No
Convulsions/seizures	Yes	No
Hemophilia	Yes	No
Asthma	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Cancer/leukemia	Yes	No
Heart trouble	Yes	No
Kidney disease	Yes	No

Explain:_____

_____

List any medications your child is currently taking: _____

_____

Immunizations: (Give date of last inoculation.) Tetanus toxoid _____/_____/_____