

ATLANTA YACHT CLUB

CHILD'S NAME _____
(Please Print)

IMPORTANT--PARENTS/GUARDIANS PLEASE READ!!!

To insure the safety of your children when involved in the AYC Junior sailing Program activities, we are asking that parents/guardians fill out this form for each participating child. This form will be required to be on file for any junior participating in any AYC Junior sailing Program.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

The undersigned parent or guardian of the above named child, a minor, do hereby consent to any emergency X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or specific supervision of, any duly licensed physician or surgeon.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and is given to provide authority and power on the part of the Atlanta Yacht Club, and each of its officers and members, to give specific consent to any and all such diagnosis, treatment or hospital care that any duly licensed physician or surgeon in the exercise of his or her best judgment may deem advisable.

This authorization shall remain effective until revoked in writing.

(Signature of Parent/Guardian) Date

(Signature of Parent/Guardian) Date

(Please Print Name)

(Please Print Name)

Preferred Personal or Family Physician

Name: _____

Phone Number: _____

Health Insurance

Company Name: _____

Policy Number: _____

Phone Number: _____

Emergency Contact (Other than Parent/Guardian)

Name: _____

Relation: _____

Phone Number: _____

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CHILD'S NAME _____
(Please Print)

Medical Information

Physical Handicaps

Specify missing or injured body parts, weaknesses, eyeglass, contacts, hearing, learning disabilities:

Bones and joints: _____
Muscles: _____
Organs: _____
Weight problem: _____
Other: _____

Physiological Handicaps

Specify problem areas such as anxieties, fears, hyperactivity, hypersensitivity:

Asthma, or other respiratory problems: _____

Circulatory or heart problems: _____
Diabetes or hypoglycemia: _____
Epilepsy: _____
Hemophilia, or other bleeding problems: _____

Allergies

Bee stings and insect bites (please specify): _____
Foods (please specify): _____
Other, if significant, including drugs/medication (please specify): _____

Other Information

Current medications & dosages: _____

Blood type: _____
Date of last Tetanus shot: _____