BALTIMORE SAILING CLUB

Junior Sailing Course
Emergency Medical Form

Participant Name			
Date of Birth		**Sailing Level**	
Allergies (incl food Allergies)			
Special Conditions			
Medications child is on			
Family Doctor		**Family Doctor Tel No:**	

In the event of an accident or injury to myself, my spouse or any child of mine (specifically including any child named above as a Participant) or in the event of myself, my spouse or any child of mine while in, or about the premises of Baltimore Sailing Club or while participating in any activity sponsored by or under the auspices of Baltimore Sailing Club under 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 said child to such medical care, attention, treatment by any hospital, Doctor or as such hospital Doctor or Doctors may deem necessary or advisable.
2. I authorise any officer or member of the Baltimore Sailing Club to consent to such medical attention or treatment.
3. I agree to pay the 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 Baltimore Sailing Club and its officers and members thereof.

The undersigned do hereby authorise and consent to any x-ray examination, anaesthetic, 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 the State Education Law and /or Public Health Law of the State and on the staff of any hospital holding a current operating certificate by the State Department of Health. It is understood that this authorisation is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power to render care, which the aforementioned Doctor in the exercise of his best judgment may deem advisable. It is understood that effort shall 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.

Parent / Guardian (Print Name)	
Parent / Guardian (Sign Name)	
Contact Telephone Numbers	