Plymouth Yacht Club Health Record 2009

This form must be completed by Parent or Guardian for each child enrolled in the program

Name: _____ Date of Birth:: _____ Sex: ____
Last First M.I.

Address: _____
Street Location Zip Code

Father's Name: _____ Mother's Name: _____

Guardian is: Father ____ Mother____ Both____ Other____ (if other, list name and address below)

_____

Telephone: Home_____ Work_____ Cell_____

Emergency notification other than parent/guardian: (name, address, phone number)

_____

Family physician or source of medical care: (name, address, phone number)

_____

Family dentist or source of dental care: (name, address, phone number)

_____

Does your child have any of the following **medical problems**: (Circle yes or no. Give details below.)

Asthma	*Yes*	*No*	Diabetes or Hypoglycemia	*Yes*	*No*
Heart/Circulatory Problems	*Yes*	*No*	Hemophilia/Bleeding Disorder	*Yes*	*No*
Epilepsy/Seizure Disorder	*Yes*	*No*	Other Medical Condition	*Yes*	*No*
Kidney or Liver Problem	*Yes*	*No*			

Details: _____

Is your child **allergic** to any of the following:

Medications	*Yes*	*No*	Bee stings/ Insect Bites	*Yes*	*No*
Foods/Peanuts	*Yes*	*No*	Other (Describe): _____		

List current **medications** if any: _____

Plymouth Yacht Club has my permission to authorize emergency care for my child. *Yes* *No*

_____
Parent/Guardian Signature **Date**

I grant my son/daughter permission to participate in the Junior Sailing Program at Plymouth Yacht Club and declare that he/she is physically and medically able to participate in such a program. I do not and will not hold Plymouth Yacht Club responsible and/or liable for any medical condition or injury my child might sustain while engaged in this program.

_____
Parent/Guardian Signature **Date**