KASZUBE CUP REGATTA
JULY 10-12 2017

South Shore Yacht Club Junior Sailing Foundation
Milwaukee, Wisconsin

MEDICAL CONSENT FORM

Each participant must fill it out completely and sign a copy of this form. Incomplete forms will not be accepted.

PARTICIPANT NAME: ____

PARENT OR GUARDIAN NAME (**if under 18**):____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child if named above as the "Participant") or in the event of illness of myself, my spouse or any child of mine while in, on or about the premises of the South Shore Yacht Club (SSYC) or while participating in any activity sponsored by or under the auspices of SSYC under circumstances where I am physically unable to consent or am not present:

1. I hereby voluntarily consent to the furnishing to myself, my spouse or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.
2. I authorize the General Manager, Assistant General Manager or any officer or member of SSYC to consent to such medical care, attention or treatment.
3. I agree to pay all costs of such medical care, attention or treatment and to hold free and harmless of and from any and all liability for such cost SSYC and its officers and members.

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, 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 by the State of Wisconsin or of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician 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.

Signature:____

Parent/Guardian Signature (**if under 18**): ____ Date:______

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

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MEDICAL AND EMERGENCY INFORMATION

Participant's name:____ Male ___ Female ___

Address:____

City/State/Zip: ____

Telephone ________________________(home) ______________________(Emergency cell)

Date of Birth: ______________________________________

THE PARTICIPANT AND/OR THEIR PARENT(S) MUST RESPOND TO THE FOLLOWING QUESTIONS AS ACCURATELY AND COMPLETELY AS POSSIBLE:

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:		ALLERGIES:	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		MEDICATION (please list below)	
DIABETES OR HYPOGLYCEMIA		LATEX	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		BEE STINGS/INSECT BITES	
CIRCULATORY OR HEART PROBLEMS		IF YES, DO YOU CARRY AN EPIPEN?	
EPILEPSY/ SEIZURE		FOODS	
OTHER		OTHER	

DATE OF LAST TETANUS/ DIPTHERIA/ TOXOID / T/d or Tdap SHOT: ________________________

CURRENT MEDICATIONS AND DOSAGE IF ANY:______________________________________

DETAILS: ____

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PLEASE MAKE SURE YOU HAVE FILLED IN ALL NECESSARY INFORMATION
If any of the above mentioned information changes before or during the event, please submit in writing all pertinent information to the regatta chairperson.

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Please Mail or Bring these forms *to*
South Shore Yacht Club Kaszube Cup
2300 E Nock St
Milwaukee, WI 53207