



Cooper River Yacht Club Sailing Programs

Confidential Medical and Emergency Information

This form must be completed and signed prior to the start of the course.

Name:	Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Address:

Do you have a history of, or do you currently have, any physical limitations that might prevent you from fully participating in this course?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please specify missing or injured bodily parts, weakness, eyeglasses, contacts, hearing aids, etc.:

Do you have any learning disability that might prevent you from fully participating in this course?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please specify:

Please check each item below that may apply and provide details on the reverse side of this form.

Chronic Ailments		Allergies	
Asthma, or other respiratory problems	<input type="checkbox"/>	Insect bites	<input type="checkbox"/>
Circulatory or heart problems	<input type="checkbox"/>	Bee stings	<input type="checkbox"/>
Diabetes or hypoglycemia	<input type="checkbox"/>	Foods	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Drugs	<input type="checkbox"/>
Hemophilia, or other bleeding problems	<input type="checkbox"/>	Other, if significant	<input type="checkbox"/>

Current medications or pertinent information:

Family physician:	Phone:	Blood type:	Date of last tetanus shot:
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Date of most recent physical examination:	Location of medical records:	Insurance Carrier:	Insurance ID#:
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Emergency Contact Information

Name:	Relation:	Home Phone:	Work Phone:
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Name:	Relation:	Home Phone:	Work Phone:
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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 under the provisions of the Education Law and/or Public Health Law of the State of New Jersey and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the state of New Jersey. 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/her best judgment may deem advisable. It is understood that effort shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

Signature:	Date:
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Applicant, or Parent/Guardian (if a minor)