

**FYC Junior Sailing Program  
Medical Information and Release**

*Participation is not permitted without completion of this form!*

Sailor's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Number & Street

City

State

Zip

Home phone: ( ) \_\_\_\_\_ Work phone: 1( ) \_\_\_\_\_ 2( ) \_\_\_\_\_

Emergency Notification (other than parent): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Medical Information**

Physician's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of last tetanus booster? \_\_\_\_\_ Blood Type: \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_ If yes, What? Why? \_\_\_\_\_

Do you have any allergies? \_\_\_\_ If yes, explain. \_\_\_\_\_

Has a doctor placed any restrictions on your activity? \_\_\_\_ If yes, explain. \_\_\_\_\_

**Liability and Medical Release**

I (We) the undersigned parent, parents or guardian of \_\_\_\_\_, a minor, understand that participation in this program is entirely at their own risk and that neither the Florida Yacht Club, the FYC Junior Fleet Committee, chaperones, sponsors nor the organizing bodies or committees or individuals appointed or volunteering accept any liability for damage-material or personal-suffering during this program, and do hereby authorize and consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act or on the staff of any acute general hospital holding a current license to operate a hospital from the State of Florida Department of Public Health or from any other state. 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 judgement 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 of the undersigned cannot be reached.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date