

MEDICAL CONSENT FORM
Maine State Optimist Championships

Name of Participant (printed): _____

Name of Parent or Guardian (printed): _____

In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named above as "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 **Kollegewidwok Yacht Club** or while participating in any activity sponsored by or under the auspices of Host Club under any 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, dentist or other medical professional as such hospital, physician, dentist or other medical professional may deem necessary or advisable.

2. I authorize any officer, volunteer or member of **Kollegewidwok Yacht Club or KSEA Sailing School** to consent to such medical care, attention or treatment.

3. I agree to pay the reasonable cost of such medical care, attention or treatment and to reimburse **Kollegewidwok Yacht Club and KSEA Sailing School**, and their respective officers, employees, contractors, volunteers or members, for any expenses any of them may incur in connection with such medical care, attention or treatment.

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 physician, dentist or other medical professional licensed under the provisions of relevant law. 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 medical professional in the exercise of his/her 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.

In case of emergency call:

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

Physician who conducted participant's Most Recent Physical Exam:

NAME: _____ PHONE: _____

DATE OF LAST EXAM: _____

HEALTH INSURANCE: _____ ID# _____

Signature of parent or guardian: _____ Date _____

(over)

MEDICAL AND EMERGENCY INFORMATION

Name of Participant: _____ SEX: ____ DOB _____

Address: _____

Phones: (B) _____ (R) _____ (C) _____

PLEASE answer the following questions as accurately and completely as possible:

Please check those that apply: (Provide details below, as appropriate):

- ___ ASTHMA, OR OTHER RESPIRATORY PROBLEMS
- ___ BEE STINGS/INSECT BITES
- ___ CIRCULATORY OR HEART PROBLEMS
- ___ CHRONIC ALLERGIES
- ___ DIABETES OR HYPOGLYCEMIA
- ___ EPILEPSY
- ___ FOODS
- ___ HEMOPHILIA, OR OTHER BLEEDING PROBLEMS
- ___ OTHERS, IF SIGNIFICANT (describe below)
- ___ MEDICATION
- ___ DETAILS / COMMENTS:

DATE OF LAST TETANUS SHOT: _____ BLOOD TYPE: _____

THIS FORM MUST BE COMPLETED AND SUBMITTED BY OR FOR ALL PARTICIPANTS

Host Club Use Only:
Reviewed
by: _____
Date
Complete: _____