

STEP 5:

NANTUCKET COMMUNITY SAILING MEDICAL FORM 2010

Student's Full Name: _____ Sex: **M** **F**

Birth Date: _____ Age: _____ Height: _____ Weight: _____

List any special conditions:

(I.e. allergies, specify injuries, weaknesses, eyeglasses, contacts, hearing aid, anxieties, hyperactivity, learning disabilities etc.)

Current medication(s) if any that your child will have with them at all times in case of an emergency (I.e. EpiPen, Epilepsy Medication etc.)

Please check those that apply and provide necessary data:

Chronic ailments:

- Asthma or other respiratory problems
- Circulatory or heart problems
- Diabetes or hypoglycemia
- Epilepsy
- Hemophilia or other bleeding problems
- Other, please describe

Allergies:

- Bee stings or other insect bites:
- Foods
- Medications
- Other, please describe

Date of last Tetanus shot: _____

Physician: _____ Phone number: _____

Dentist: _____ Phone number: _____

Health Insurance Provider: _____ ID #: _____

Emergency contacts:

Name	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the supervision of any qualified health care professional or staff of any hospital holding a current operational 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 the above treatment will not be withheld if the undersigned cannot be reached.

Signed: _____ **Date:** _____