

## Rochester Canoe Club Emergency Medical Consent Form

Please include when submitting a Registration Form. Only completely filled in forms will be accepted.

Participant:		Parent/Guardian:	
Height:	Weight:	Birthdate:	Sex: M ___ F ___
Address:			
City, State:		Zip:	Phone:

Physical Disabilities	Chronic Ailments	Allergies
Please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, etc.	Check those that apply. Provide necessary details on a separate sheet. <input type="checkbox"/> Asthma or other respiratory problems <input type="checkbox"/> Circulatory or heart problems <input type="checkbox"/> Diabetes or Hypoglycemia <input type="checkbox"/> Hemophilia or other bleeding problems <input type="checkbox"/> Epilepsy	Check any that apply. <input type="checkbox"/> Insect Bites <input type="checkbox"/> Foods <input type="checkbox"/> Bee Stings <input type="checkbox"/> Other, if significant

Date last Tetanus Shot:	Current Medications, if any:	
Physician who conducted most recent physician examination:		
Physician's Phone #:	Health Ins. Carrier:	Insurance ID #:
Is there any additional information concerning your child that the club should be made aware of?		

### MEDICAL WAIVER AGREEMENT

*In the event of accident or injury to myself, my spouse or any child of mine (specifically including my child named below 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 Rochester Canoe Club or while participating in any activity sponsored by or under the auspices of the Rochester Canoe Club 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 any officer or member or agent of the Rochester Canoe Club 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 indemnify and hold free and harmless of and from any and all liability for such cost the Rochester Canoe Club and the United States Sailing Association and its officers and members thereof.*

*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 State Education Law and/or Public Health Law of the State and on the staff 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.*

*In the event of any emergency, I/we can be reached as follows:*

Mother's Name:	Home Phone:
Signature:	Office, Cell, Pager:
Father's Name:	Home Phone:
Signature:	Office, Cell, Pager:

If I/we cannot be reached, you are authorized to contact:

Name:	Home Phone:
Relationship:	Office, Cell, Pager:

PLEASE MAKE SURE BOTH FORMS ARE COMPLETED