Shreveport Yacht Club Sailing Education
Medical & Emergency Information

This form must be completed and signed by you or your parents (if you are a minor) and turned in prior to the start of your course.

Name_____ Birth date _____Sex_____

Address_____
No. Street City State Zip

Do you have a history of or do you currently have any physical limitations that might prevent you from participating in this course? ____Yes _____No
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? _____Yes _____No. If yes, please specify._____

Please check (√) those that apply and provide necessary information on reverse side of this form.

Chronic Ailments
- Asthma or other respiratory problems _____
- Circulatory or heart problems _____
- Diabetes or hypoglycemia _____
- Epilepsy _____
- Hemophilia or other bleeding problem _____

Allergies
- Insect bites _____
- Bee stings _____
- Foods _____
- Drugs _____
- Others, if significant _____

Current medications or pertinent information_____

Blood Type _____ Date of last tetanus shot_____

Family physician name _____Phone_____

Date of most recent examination_____

Where are your medical records kept? _____

Insurance Carrier_____ Insurance ID#_____

Who should be notified in case of emergency?

Name_____ Relation_____

Phone _____ (B) _____ (O) _____

Name_____ Relation_____

Phone _____ (B) _____ (O) _____

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 Louisiana and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of Louisiana. 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 judgement 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_____
Applicant or Parent/Guardian (if minor)