Child's Name _____ Age _____

DEEP CREEK SAILING SCHOOL, Inc.

IMPORTANT -- PARENTS PLEASE READ

To insure the safety of your children when involved in the Deep Creek Sailing School activities, we require that parents execute this medical release for each child so that the child could receive medical treatment in the event of an emergency. This form will be kept at the club during sailing activities.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

The undersigned parent or guardian of _____, a minor, do hereby consent to any emergency X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon duly licensed.

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 on the part of our agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgment may deem advisable, and neither said agent nor any organization involved assumes any financial responsibility for exercising this action.

Family Doctor _____Phone number _____
Persons to contact in emergency:

1. _____Phone number _____
2. _____Phone number _____

Medical / learning problems_____

Known allergies_____

Hospital Insurance Plan #_____

This authorization shall remain effective for (dates) _____or until revoked in writing.

Signature_____ Date _____

Printed Name _____ (Parent) (Guardian)

Mother's Phone(Home)_____(Work)_____

(Cell) _____

Father's Phone(Home)_____(Work)_____

(Cell) _____