



# Racine Yacht Club

## Sailing School Health Form

THIS FORM IS TO BE COMPLETED AND SUBMITTED BEFORE ATTENDING SAILING SCHOOL. An actual physical for sailing school is NOT necessary so long as all information is complete, correct, and that the youth sailor has had a physical in the past 36 months.

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth date \_\_\_\_\_  
last first middle

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Home Phone (     ) \_\_\_\_\_ Business Phone (     ) \_\_\_\_\_

Email address that you check: \_\_\_\_\_

If not available, in an EMERGENCY we should contact:

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

### Part One --- Parental Authorization

I understand and certify that my child's participation in the RYC sailing school program is completely voluntary. I understand that certain hazards and dangers are inherent in the sailing program, and I acknowledge that although Racine Yacht Club has taken measures to minimize the risk of injury to student participants, the Racine Yacht Club cannot guarantee that the activities will be free of accidents or injuries. Furthermore, I have instructed my child in the importance of abiding by the Sailing School rules and procedures for the safety of all sailors.

I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the attending physician secured by the Racine Yacht Club to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

Please provide your medical insurance information:

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Carrier Phone Number (     ) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ SS# \_\_\_\_\_

## Part Two --- Health Information

### Basic Health History:

- |  |                                      |   |  |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> asthma      | <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> diabetes      |
| <input type="checkbox"/> heart defect            | <input type="checkbox"/> convulsions | <input type="checkbox"/> epilepsy           | <input type="checkbox"/> hyperactivity |
| <input type="checkbox"/> hypertension            | <input type="checkbox"/> bedwetting  | <input type="checkbox"/> sleepwalking       |  |

### Allergies:

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> penicillin       | <input type="checkbox"/> serious poison ivy | <input type="checkbox"/> bee stings |
| <input type="checkbox"/> hay fever        | <input type="checkbox"/> food allergies     | <input type="checkbox"/> aspirin    |
| <input type="checkbox"/> other (specify): |   |                                     |

**Immunizations:** All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

\_\_\_\_\_ DPT                      \_\_\_\_\_ Polio                      \_\_\_\_\_ Measles

\_\_\_\_\_ Current Tetanus (If date cannot be supplied, please initial this statement: "In case of an emergency, the attending physician may administer a tetanus booster." \_\_\_\_\_)

Operations, Serious or Chronic Illnesses:

Dietary Allergies:

Drugs currently taken, prescribed or un-prescribed:

*(RYC staff instructors WILL NOT administer drugs of any type)*

## Part Three --- Health Examination Record

This health history record is correct so far as I know, and the person herein described has permission to engage in all on the water activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 36 months.

Physical Restrictions: \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name & Phone # of Family Physician \_\_\_\_\_ (     ) \_\_\_\_\_