

2009 CLUB 420 ASSOCIATION NORTH AMERICAN CHAMPIONSHIP

HEALTH CARE AND EMERGENCY INFORMATION
AUTHORIZATION FOR HEALTH CARE TREATMENT

NAME: _____ GENDER: M ___ F ___ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____ COUNTRY _____

TELEPHONE: _____ (R) _____ (B)

ADULT RESPONSIBLE FOR COMPETITOR AT EVENT _____ ADULT CELL # _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE.

(Check those that apply and provide necessary details).

CHRONIC AILMENTS:		ALLERGIES:	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS:		MEDICATION	
DIABETES OR HYPOGLYCEMIA		BEE STINGS/INSECT BITES	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		FOODS	
CIRCULATOR OR HEART PROBLEMS:		OTHERS, IF SIGNIFICANT	
EPILEPSY			

CURRENT MEDICATIONS, IF ANY: _____

DETAILS: _____

HEALTH INSURANCE CARRIER: _____ Certificate # _____

PRIMARY CARE PHYSICIAN _____ Phone # _____

AUTHORIZATION FOR TREATMENT:

In the event my child, _____, is injured or ill while attending the 2009 Club 420 Association Championship at the Macatawa Bay Yacht Club, I hereby give my permission for the administration of all reasonable health care treatment. I expressly authorize any officer, member or volunteer from either the Macatawa Bay Yacht Club or the Club 420 Association, Inc. to consent to such health care treatment. Such treatment may include but is not limited to X-ray examination, dental, anesthesia, medical or surgical diagnosis or treatment. I understand that this authorization is given in advance of any specific diagnosis or treatment or hospital care. It is given to provide the authority and power to the health care professionals to exercise their best professional judgment. It is understood that efforts will be made to contact me prior to providing such treatment but I also understand that the treatment may occur if I cannot be contacted.

I also agree to pay the reasonable cost of any such health care attention or treatment and to reimburse the Macatawa Bay Yacht Club, the Club 420 Association, Inc. or any person who incurs expenses for this health care treatment.

(Parent Signature)

(Date)

(Parent Signature)

(Date)