KI Sailing LTD Youth Sailing
Spring 2021 KI High School Team

P.O. Box 454, Stevensville, MD 21666 www.kisailing.org email: info@kisailing.org

CONTACT INFORMATION

Child's Name:_____Date of Birth:_____M/F: _____

Current Residence: _____

Child's email (used for group communication): _____

Child's phone (used for group communication): _____

Sailing experience : _____

Parent/Legal Guardian:_____Email:_____Phone: _____

Parent/Legal Guardian:_____Email:_____Phone: _____

Emergency contact:_____Phone: _____

Primary care physician:_____Phone: _____

HEALTH HISTORY

Existing medical or learning problems?

_____No_____Yes, explain: _____

_____

Any medications, dietary restrictions, allergies, etc?

_____No_____Yes, explain: _____

_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, the undersigned parent or guardian of_____, a minor, do hereby consent to any emergency X-ray, medical, or surgical treatment or hospital care which is deemed appropriate by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act. My child(ren) and I are covered by Medical Insurance.

It is understood that this authorization is given to provide authority and power on the part of the aforesaid 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 judgement may deem advisable; and neither said agents or organizations involved assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the applicable Civil Code for the State of Maryland.

This authorization to consent to treatment of minor shall remain effective until December 31, 2021 or revoked in writing.

Signature (Parent or Legal Guardian):_____Date: _____