

Sailing School Health Form

THIS FORM IS TO BE COMPLETED AND SUBMITTED BEFORE ATTENDING SAILING SCHOOL.

Student's Name _

You may scan and email to ppmsail@shmarinas.com, fax to (860) 399-8720, or mail to Pilots Point Marina, Attn: Sailing School, 63 Pilots Point Drive, Westbrook, CT 06498.

__ 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 Pilots Point Marina sailing school program is completely voluntary. I understand that certain hazards and dangers are inherent in the sailing program, and I acknowledge that although Pilots Point Marina has taken measures to minimize the risk of injury to student participants, Pilots Point Marina 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 Pilots Point Marina to transport my child to a medical facility and to the attending physician secured by Pilots Point Marina 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 ()



Part Two – Health Information

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

			Data	of Exam/_	/
			Date	OI Exam/_	/
May participa	te in all camp activiti	es			
May participa	te except for:				
Medical information pe	ertinent to routine car	e and emergencies:			
Is this individual taking	g prescription or over	the counter medication	on(s)? YES	□ NO	
If yes, indicate names of	of medication(s):				
Does the individual hav	ve allergies?	s No	Explain:		
Is the individual on a sp	pecial diet? YE	_			
Does the individual hav	ve special needs?	YES NO	Explain:		
	_	_	•	rrently recommended by th	_
Academy of Pediatrics a	and National Advisory	Committee on Immu	nization Practices:	rrentry recommended by the	ie American
	Y	N		Y	N
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		
		•	1		
Comments:					
Print name of medical c	are provider:				
Medical care provider's	address:				
Medical care provider's: City/Town			ST	Zip Code	
Signature of Physician, I	PA, APRN or RN:				
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