

**2008 CLUB 420 ASSOCIATION NORTH AMERICAN CHAMPIONSHIP
HEALTH CARE AND EMERGENCY INFORMATION
AND
AUTHORIZATION FOR HEALTH CARE TREATMENT**

NAME: _____ GENDER _____ (M) _____ (F)

ADDRESS: _____
Street/P.O. Box

City State Zip

TELEPHONE _____ (R) _____ (B)

DATE OF BIRTH: _____

ADULT RESPONSIBLE FOR COMPETITOR AT EVENT: _____

ADULT'S CELL #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:	ALLERGIES:
ASTHMA, OR OTHER RESPIRATORY PROBLEMS	MEDICATION
DIABETES OR HYPOGLYCEMIA	BEE STINGS/INSECT BITES
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	FOODS
CIRCULATORY 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 2007 Club 420 Association Championship at the Chautauqua Lake 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 Chautauqua Lake Yacht Club or the Club 420 Association 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 Chautauqua Lake Yacht Club , the Club 420 Association, or any person who incurs expenses for this health care treatment.

(parent signature)

(date)

(parent signature)

(date)