

Elite Sailing LLC
2017-2018 Medical/Emergency Information

Participant Information:

Last Name: _____		First Name: _____	
DOB: _____	Age _____	Height _____	Weight _____

Family Information:

Parent/Guardian Name: _____		Relationship: _____	
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
Local Address: _____			
Parent/Guardian Name: _____		Relationship: _____	
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
Local Address: _____			

Emergency Contacts:

Name: _____		Relationship: _____	
Cell Phone #: _____	Home Phone #: _____		
Name: _____		Relationship: _____	
Cell Phone #: _____	Home Phone #: _____		

Medical Information:

Check if "Yes" and provide details

Chronic Conditions

____ Asthma or other respiratory problems: _____
____ Circulatory or heart problems: _____
____ Diabetes or hypoglycemia: _____
____ Epilepsy or seizures: _____
____ Hemophilia or other bleeding problems: _____
____ Speech, hearing, or visual impairment: _____
____ Other: _____

Allergies

____ Foods: _____
____ Medications: _____
____ Other, if significant: _____

Mental/Emotional/Social Health

____ Learning Disability: _____
____ ADD or ADHD: _____

Please describe any behavioral, emotional, social, or other special needs or conditions:

Other

____ Serious injury: _____
____ Surgery for: _____
____ Physical problems or handicaps: _____
____ Other mental/physical health related issues: _____

Please list any current medications: _____

Date of Last Tetanus Shot: _____

Physician & Insurance Information:

Family physician: _____ Phone #: _____

Health Insurance Company: _____

Policy number: _____ Group number: _____