2026 DRYA JUNIOR SAILING
MEDICAL AND EMERGENCY INFORMATION

NAME:_____ SEX _(M)_(F)

DOB:_____

ADDRESS:_____

Street City State Zip

TELEPHONE _____(H)_____(C)

PHYSICAL HANDICAPS (Please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, etc.)

Please check () those that apply: (Provide necessary details on reverse side of this sheet.)

CHRONIC AILMENTS:		ALLERGIES	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		MEDICATION (please list below)	
DIABETES OR HYPOGLYCEMIA		BEE STINGS/INSECT BITES	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		IF YES, DO YOU CARRY AN EPIPEN?	
QRCULATORY OR HEART PROBLEMS		LATEX	
EPILEPSY/SEIZURE		FOODS	
OTHER		OTHER	

DATE OF LAST TETANUS/DIPTHERIA/TOXOIDSHOT _____ BLOOD TYPE _____

CURRENT MEDICATIONS AND DOSAGE IF ANY:_____

DETAILS _____

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME _____ - **PHONE NUMBER** DATE **OF LAST EXAM**

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUWSER

SIGNATURE OF APPLICANT: _____ DATE:_____