

2010 SSC YOUTH SAILING CLINICS
REGISTRATION FORM

June 26, 10 am – 3 pm
July 17, 10 am – 3 pm
August 7, 10 am – 3 pm
August 21, 10 am – 3 pm

Location: at Seabrook Sailing Club
Members Only

Sailor: _____

Address: _____ City: _____ State + Zip _____

Telephone: _____ Email: _____

Date of Birth: _____ Level: Beginner / Intermediate

Fee: \$ 80.00 for 4 clinics

Make checks payable to: Seabrook Sailing Club

Bring registration including Medical Consent Form to Clinic.

Class will be held rain or shine. (In case of storm or flood, check web site for updated information)

LIABILITY RELEASE AGREEMENT

IN CONSIDERATION OF ACCEPTANCE OF MY CHILD'S REGISTRATION TO PARTICIPATE IN THE CLINICS AND, RECOGNIZING THE RISKS ASSOCIATED WITH THE SPORT OF SAILING, THE UNDERSIGNED HEREBY WAIVES ALL CLAIMS FOR PERSONAL INJURY AND PROPERTY DAMAGE AND HEREBY RELEASES THE TEXAS SAILING ASSOCIATION, THE HOST CLUB AND THEIR DIRECTORS, OFFICERS, MEMBERS, EMPLOYEES, AND THE REGATTA VOLUNTEERS AND SPONSORS, OF AND FROM ANY AND ALL CLAIMS, INCLUDING THOSE OF NEGLIGENCE AND GROSS NEGLIGENCE, WHICH I OR MY CHILD MIGHT HAVE, ARISING OUT OF MY CHILD'S PARTICIPATION IN THE CLINICS AND ALL ACTIVITIES RELATING THERETO.

Parent or Guardian's Signature: _____

Date: _____

MEDICAL CONSENT FORM

NAME OF PARTICIPANT: _____

AGE: _____

NAME OF PARENT/GUARDIAN (printed): _____

HOME ADDRESS: _____

TELEPHONE NO: _____ CELL PHONE: _____

In the event of accident, injury or illness involving any child of mine (specifically including my child named above as the "Participant") or me or my spouse while in, on, or about the premises of Seabrook Sailing Club or while participating in any activity sponsored by or under the auspices of said Club under circumstances where I am physically unable to consent or am not present,

1. I hereby voluntarily authorize and consent to the furnishing to myself, my spouse, or any child of mine of such medical care, attention, and treatment by any hospital, physician or dentist as such hospital, physician or dentist may deem necessary or advisable, including any x-ray examination, anesthetic, medical, or surgical diagnosis or procedure.
2. I authorize any adult associated with the activity to consent to such medical care, attention and treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost the assisting adult, the Club and the officers, employees and members of said organizations.

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.

ALTERNATIVE PERSONS TO CONTACT: _____

PHONE NUMBERS (incl. mobile phone): _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: _____

ATTACH COPY OF HEALTH INSURANCE CARD, OR COMPLETE THE FOLLOWING:

HEALTH INSURANCE CARRIER INSURANCE ID NO.: _____

NAME OF INSURED: _____

PHONE NO. FOR VERIFICATION CLAIMS _____

MAILING ADDRESS : _____

I agree that a photocopy of this consent or a copy sent by facsimile may be accepted by any health care providers. This consent shall be valid for one (1) year from the date of signing.

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____