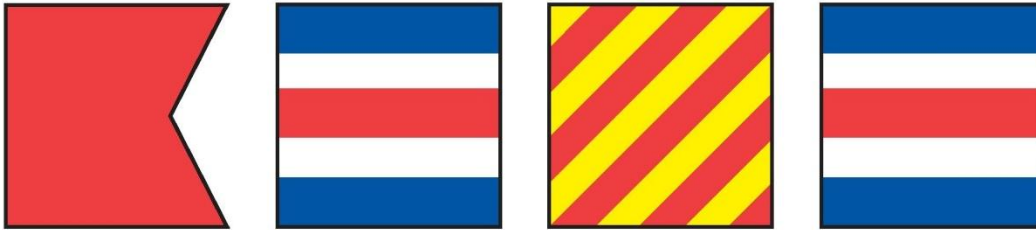

CAMP CORINTHIAN

BCYC Summer Sailing Program

EMERGENCY MEDICAL RELEASE

Participant's Name: ____ Date of Birth: ________________ Age______

Address ____________________________________ City ____________________________ State_____ Zip ___________

Mother's Name ___________________________________ Father's Name _______________________________________

Home Phone _____________________________________ Home Phone _______________________________________

Work Phone ______________________________________ Work Phone ____

Mobile Phone _____________________________________ Mobile Phone _______________________________________

Physician ____ Phone ____

Insurance Co ________________________ Insured's Name ___________________________ Policy ___________________

Has the Program Participant ever been treated for:

☐ Disease of the bones or joints ☐ Heart Disease ☐ Asthma ☐ Rheumatic Fever

☐ Chronic Disease of the lung ☐ Chronic Ear Disease ☐ Epilepsy ☐ Other (explain on back)

List any medications participant is currently or recently taking: ____

List any allergies (medications, bee stings, etc): ____

Any vision or hearing conditions: ____

I/We, the undersigned parent(s) legal guardian(s) of ________________________, do

hereby authorize & consent, for a period of 12 months from the date noted below, to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision or any members of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State's Department of Public 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 with the aforementioned physician in the exercise of his/her 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 treatments will not be withheld if the undersigned cannot be reached.

Parent Signature: ___________________________________ Date: ________________

Emergency Contact: _________________________________ Phone: ________________

Emergency Contact: _________________________________ Phone: ________________

Bahia Corinthian Yacht Club 1601 Bayside Drive Corona Del Mar, CA 92625