MEDICAL CONSENT FORM
Junior Program
Chautauqua Lake Yacht Club

Name of Participant (printed): _____

Name of Parent or Guardian (printed: _____

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

1.I hereby voluntarily consent to the furnishing to myself, my spouse or any of my said children of such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.

2.I authorize any officer or member of the Chautauqua Lake Yacht Club to consent to such medical care, attention or 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 Chautauqua Lake Yacht Club, and its officers and members thereof.

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/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 treatment will not be withheld if the undersigned cannot be reached.

In case of emergency call:

NAME:_____

RELATIONSHIP:_____

PHONE NUMBER:_(_____)_____-_____

Signature of parent or guardian: _____

Date: _____