Chappaquiddick Community Center, Inc.
Medical Information & Consent Form

CIRCLE PROGRAM(S): **Tennis** **Sailing** **TTOR**

PARTICIPANT (printed):_____SEX____D.O.B. _____

Address on Chappy: _____

Please check those that apply (Provide necessary details below):

Chronic Ailments	Allergies
Asthma/Respiratory Problems	Medication
Diabetes or Hypoglycemia	Bee Stings/Insect bites
Hemophilia/Other bleeding problems	Foods
Circulatory/Heart Problems	Others
Epilepsy	

DETAILS: _____

In the event of accident or injury to myself, my spouse, or any child of mine (specifically including my child named above as the "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 Chappaquiddick Community Center, Inc., or while participating in any activity sponsored by or under the auspices of said Center under 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 may deem necessary or advisable.
2. I authorize any officer of the Community Center 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 to the Community Center and its officers, directors and employees.

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 in the Commonwealth of Massachusetts and on the staff of any hospital holding a current operating certificate issued by the Commonwealth. 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

_____ _____ _____
NAME RELATIONSHIP PHONE

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____
HEALTH INSURANCE COMPANY INSURANCE ID. #