PILOTS POINT
BREWER
MARINA

Sailing School Health Form

THIS FORM IS TO BE COMPLETED AND SUBMITTED BEFORE ATTENDING SAILIING SCHOOL. You may scan and email to ppmsail@byy.com, fax to (860)399-8720 or mail to Pilots Point Marina, Attn Sailing School, 63 Pilots Point Drive, Westbrook, CT 06498.

Student's Name ______________________ Sex _______ Birth date ______________
last first middle

Home Address ____

City ______________________ State ______ Zip ______________

Parent/Guardian Name ____

Home Phone ( ) ______________ Business Phone ( ) ______________

Email address that you check:______________________________________

If not available, in an **EMERGENCY** we should contact :

Name ______________________ Phone ( ) ______________

Name ______________________ Phone ( ) ______________

Part One --- Parental Authorization

I understand and certify that my child's participation in the Pilots Point Marina sailing school program is completely voluntary. I understand that certain hazards and dangers are inherent in the sailing program, and I acknowledge that although Pilots Point Marina has taken measures to minimize the risk of injury to student participants, Pilots Point Marina cannot guarantee that the activities will be free of accidents or injuries. Furthermore, I have instructed my child in the importance of abiding by the Sailing School rules and procedures for the safety of all sailors. I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an **EMERGENCY**, I hereby give permission to Pilots Point Marina to transport my child to a medical facility and to the attending physician secured by Pilots Point Marina to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child.

Signature of Parent ______________________ Date ______________________

Please provide your medical insurance information:

Insurance Carrier ______________________ Policy # ______________________

Insurance Carrier Phone Number ( ) ______________________

Policy Holder's Name ______________________

Part Two --- Health Information

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/_____

_______ May participate in all camp activities

_______ May participate except for: ____

____

Medical information pertinent to routine care and emergencies: ____

____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):____

Does the individual have allergies? ☐ YES ☐ NO Explain: ____

Is the individual on a special diet? ☐ YES ☐ NO Explain: ____

Does the individual have special needs? ☐ YES ☐ NO Explain: ____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: ____

____

____

Print name of medical care provider: ____

Medical care provider's address: ____

Medical care provider's: City/Town ____________________ ST ________ Zip Code ________

Signature of Physician, PA, APRN or RN ____

Date Form Signed ____

Telephone Number ____