Sailing Health Form

Antique Boat Museum

Camper Information

Name: _____ DOB: _____ ◯ Male ◯ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work/Cell: _____

Name of parent/guardian(s): _____

Emergency Contact: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work/Cell: _____

Insurance Information

Carrier: _____ Identification #: _____

Policy Holder's Name: _____ Relationship: _____

Employer: _____

Medical Information/Conditions

Physician's Name: _____ Phone: _____

Please list any conditions that would impede participation (including hearing & eyesight):

_____

_____

Please list any allergies (medication or other): _____

_____

Do you have any of the following conditions?

- ☐ Heart condition/Hypertension
- ☐ Diabetes
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Other: _____

Medications

Please list any medications you are currently taking:_____

_____

Do you have an epi-pen or inhaler? Do you have it with you? _____

_____

Signature: _____ **Date:** _____