These forms (two pages) are required at time of registration for any youth sailing classes or sailing team

Hunterdon Sailing Club

Medical & Transportation Waiver

I/we, the undersigned parents/guardians of _____
a minor, do hereby authorize the Hunterdon Sailing Club, Inc. as our agents to consent to any diagnostic procedure or medical care which is deemed advisable by and is rendered under the general or special supervision of any licensed physician or surgeon on the staff of the Hunterdon Medical Center, whether such treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until the child withdraws from any Hunterdon Sailing Club training program unless sooner revoked in writing and delivered to said agent(s).

Also, I hereby waive and release any and all rights and claims for damages I may have against the Hunterdon Sailing Club, its representatives and assigns for any and all injuries suffered by my child in transit.

_____ _____
Parent/Guardian's Signature Date

_____
Emergency Contact/Phone number

_____
Emergency Contact/Phone number

_____
Emergency Contact/Phone number

_____
Emergency Contact/Phone number

Individuals who may pick-up child (name + relationship):

_____

Mail completed forms to: HSC/ Mike Wheeler, 8 Oxford Rd., Wharton, NJ 07885

UNIVERSAL CHILD HEALTH RECORD

Endorsed by:

American Academy of Pediatrics New Jersey Chapter | *New Jersey Department of Health and Senior Services* | *New Jersey Academy of Family Physicians*

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Date of Birth / /

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight*(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐Immunization Record Attached ☐Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐None ☐Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐None ☐Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐None ☐Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐None ☐Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐None ☐Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐None ☐Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐None ☐Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐None ☐Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐Capillary ☐Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	