



Sailing Lessons 2008

The Buffalo Yacht Club

Health History Form

Name: _____ Date of Birth: _____

Address: Street _____

City _____ State/Zip _____

Telephone:(____)_____ E-Mail: _____

Emergency Information: Person(s) to notify in case of emergency

Name: _____ Relationship: _____

Address: Street _____

City _____ State/Zip _____

Telephone:(____)_____

Primary Care Physician:

Name: _____ Telephone: (____)_____

Address: Street _____

City _____ State/Zip _____

Do you have or ever had any of the following:

YES

NO

Allergies

Convulsions

Diabetes

Heart Trouble

Fainting Spells

A condition requiring regular medical attention or medication

Impaired hearing

Impaired eyesight

Have you been hospitalized during the last 3 years

Have you been examined or treated by a physician or health care provider during the last 3 years for any medical problem other than regular checkups?

To your knowledge, do you have any condition medical or otherwise that would prevent you from participating in the Buffalo Yacht Club Sailing Program, including on water activities?

Are you taking prescribed medication regularly?

Signature: _____

Date: _____