



# Buffalo Yacht Club Junior Sailing Health History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: Street \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_

Telephone: \_(\_\_\_\_)\_\_\_\_\_

## **Emergency Information**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Telephone: Home \_(\_\_\_\_)\_\_\_\_\_ Telephone: Home \_(\_\_\_\_)\_\_\_\_\_

Work \_(\_\_\_\_)\_\_\_\_\_ Work \_(\_\_\_\_)\_\_\_\_\_

## **If Parents Can Not Be Reached**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: Street \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_

Telephone: Home \_(\_\_\_\_)\_\_\_\_\_

Work \_(\_\_\_\_)\_\_\_\_\_

## **Family Physician**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: Street \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_

## **Health Insurance**

Medical Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Does your child presently have or has he/she 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	_____	_____
Has your child been hospitalized during the last 3 years?	_____	_____
Has your child been examined or treated by a physician or health care provider during the last 3 years for any medical problem other than regular checkups?	_____	_____
Does your child presently take any medication?	_____	_____

If yes, please provide name and dosage of each medication:

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\* If you answered yes to any of the above health history questions, please provide additional information on a separate sheet, which should be securely fastened to this form.

**Date of immunizations**

Tetanus Toxoid	_____	Measles	_____
Polio	_____	German Measles	_____
Mumps	_____	Diphtheria	_____

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_