



**BYC Boating Education Enrollment Form
2019 – Buffalo Clubhouse**

(Please Complete One Form Per Participant & PLEASE PRINT NEATLY)

Participant's Full Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 City/State/Zip: _____ Birthday: _____
 Email: _____ School & Grade Attending: _____
 How did you hear about our program: _____

Brief Description of Previous Sailing Experience:

If under 18 years:

Parent/Guardian Full Name(s): _____
 Mother's Contact Phone: _____ Father's Contact Phone: _____
 Mother's E-Mail: _____ Father's E-Mail: _____

Session(s) Requested	Program	Dates Requested	Member Cost (Parent/Grandparent)
	Weekly Camp 1	7/1 – 7/5**	\$300
	Weekly Camp 2	7/8 – 7/12	\$300
	Weekly Camp 3	7/15 – 7/19	\$300
	Weekly Camp 4	7/22 – 7/26	\$300
	Weekly Camp 5	7/29 – 8/2	\$300
	Weekly Camp 6	8/5 – 8/9	\$300
	Weekly Camp 7	8/12 – 8/16	\$300
	Weekly Camp 8	8/19 – 8/23	\$300
	2 Week Camp (please mark)		\$550 (save \$50)
	4 Week Camp (please mark)		\$1,000 (save \$200)
	8 Week Camp (please mark)		\$1,900 (save \$500)
	Daily Camp (please specify)		\$65
Total Fees Due			

Send Completed Form & Payment to:

Buffalo Yacht Club Boating Education
 One Porter Avenue
 Buffalo, NY 14201
 Voice: (716) 883-5900 Fax: (716) 883-7806

Payment Method: Check # _____ BYC Member # _____

**** No camp on July 4th ****

If selecting that week, please let us know which day you would like to attend as a make-up: _____



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:

* 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 _____

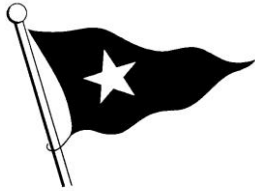


PHOTO RELEASE FORM



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Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____