



Magothy River Sailing Association

Student Name _____
Address _____
Date of Birth _____ Parent/Guardian Phone _____
Parent/Guardian Name _____

MEDICAL WAIVER:

I/We, parents or guardian of (student's Name) _____ authorize and consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any member of the medical staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and the staff of any acute general hospital holding a current license to operate from the State of Maryland Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care that the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if he undersigned cannot be reached.

Parent or Guardian _____ Date _____

Medical Notes (allergies, special conditions, current medications, etc. – use attachments as necessary):

Medical History (Chronic Conditions or Recent Injury/Illness):

Current Medications:

Medical Allergies (if none, please write 'NONE'):

Other Pertinent Information: