MEDICAL CONSENT FORM and
<u>LIABILITY RELEASE AGREEMENT</u>

NAME OF PARTICIPANT: ____**AGE:**__________

NAME OF PARENT/GUARDIAN (printed): ____

HOME ADDRESS:____

TELEPHONE NO:______________________________ **CELL PHONE**: ___________________________

In the event of accident, injury or illness involving any child of mine (specifically including my child named above as the "Participant") or me or my spouse while in, on, or about the premises of a Texas Sailing Association ("TSA") member yacht club (the "Club") (which includes the [name of Host Yacht/Sailing Club]) or while participating in any activity sponsored by or under the auspices of said Club under circumstances where I am physically unable to consent or am not present,

1. I hereby voluntarily authorize and consent to the furnishing to myself, my spouse, or any child of mine of such medical care, attention, and treatment by any hospital, physician or dentist as such hospital, physician or dentist may deem necessary or advisable, including any x-ray examination, anesthetic, medical, or surgical diagnosis or procedure.
2. I authorize any adult associated with the activity to consent to such medical care, attention and treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost the assisting adult, the Club, TSA and the officers, employees and members of said organizations.

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 the undersigned cannot be reached.

ALTERNATIVE PERSONS TO CONTACT:

____

NAME RELATIONSHIP PHONE NUMBERS (Including Mobile Phone Number)

PRIMARY CARE PHYSICIAN:

____

NAME PHONE NUMBER

ATTACH COPY OF HEALTH INSURANCE CARD, OR COMPLETE THE FOLLOWING:

____

HEALTH INSURANCE CARRIER INSURANCE ID NO. NAME OF INSURED

____

PHONE NO. FOR VERIFICATION CLAIMS MAILING ADDRESS

I agree that a photocopy of this consent or a copy sent by facsimile may be accepted by any health care providers.
This consent shall be valid for one (1) year from the date of signing.

_____________________________________ _______________________

SIGNATURE OF PARENT/GUARDIAN **DATE**