

THE INTERNATIONAL GP14 CLASS ASSOCIATION
Medical consent and emergency contact form
THIS IS A MANDATORY REQUIREMENT

THIS FORM IS DOUBLE SIDED – PLEASE ENSURE YOU TURN OVER

Please complete all sections in **BLOCK CAPITALS**

This information will be kept in your sealed envelope and only opened in the event of an emergency.

SAILOR'S DETAILS

| | |
|----------------|--|
| Sailor Name: | |
| Home Address: | |
| Date of birth: | |
| Age: | |

EMERGENCY CONTACTS

Emergency Contact

| | |
|----------------|--|
| Name: | |
| Relationship: | |
| Home Number | |
| Work Number | |
| Mobile Number: | |

Alternative Emergency Contact

| | |
|----------------|--|
| Name: | |
| Relationship: | |
| Home Number | |
| Work Number | |
| Mobile Number: | |

Please make sure that you have notified the nominated people of your intention to use them as emergency contacts.

DOCTOR DETAILS

| | | | |
|----------------|--|--------------|--|
| Doctor's Name: | | Work Number: | |
|----------------|--|--------------|--|

It is your responsibility to make known any potential medical conditions that may affect you during the activities associated with the event you will be taking part in. Please therefore provide as many details as possible. This information will be shared with the organisers at events.

Have you ever suffered from any of the following conditions:

- | | | |
|-----------------------------------|-----|----|
| • Asthma/bronchitis | Yes | No |
| • Heart conditions | Yes | No |
| • Fits, fainting or blackouts | Yes | No |
| • Severe headaches | Yes | No |
| • Diabetes | Yes | No |
| • Travel sickness | Yes | No |
| • Allergies to medication | Yes | No |
| • Any other allergies | Yes | No |
| • Other illnesses or disabilities | Yes | No |

If you have answered yes to any of the above, please provide details in the box below.

When did you last have a tetanus vaccination?

Year

Are you currently taking any medication? If so please specify:

Are you suffering/recovering from any injuries which may affect your sailing?

Are you vegetarian? Yes No

Do you have any food allergies? If so, please specify:

Consent

I give permission to the organisers of activities during the period
(dates of event) to administer any relevant treatment or medication to the above-named participant when or if necessary.

In an emergency situation I authorise the organisers to take me to hospital and give my full permission for any treatment required to be carried out in accordance with the hospital's diagnosis

Signed:

Date: