

MEDICAL EMERGENCY AUTHORIZATION

I hereby authorize the Bellport Bay Sailing Foundation, and its employees, agents or representatives, or any adult who bears this document, to authorize emergency treatment of the below listed participant in the event a parent or legal guardian cannot be contacted at the time of the emergency at the telephone numbers below.

_____ Sailor	_____ Date of Birth
_____ Signature of Parent	_____ Date
_____ Emergency Telephone Number	_____ Home Phone Number
_____ Alternate Contact Person	_____ Alternate's Phone Number
_____ Primary Care Physician	_____ Physician's Telephone Number
_____ Insurance Carrier	_____ Identification Number
Special Diet Required	Yes No
Special Health Concerns	Yes No

Please attach information relevant to other medical information, allergies, or special health requirements.