COST OF PROGRAM IS $90.00 PER WEEK PER STUDENT

Pentwater Junior Sailing Program
Registration Form

These forms must be completed and signed by the parent or legal guardian of the student before he/she can participate in the program.

Permanent Address

Name: _____ Age: _____ Grade: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

Local Address

Street: _____

City: _____ Zip: _____

Phone: _____ Email: _____

* Email is the most effective way for us to keep you informed about program information including scheduling or schedule changes.

Week-long sessions Monday thru Friday running from: **July 2 thru August 10**
Children 12 years and under must take two weeks in the Prams (beginners), and be able to sail the Pram solo before moving up to the Sunfish (intermediate) class.

Week you would like to start	

Has your child been in the Sailing Program before?		Yes ☐ No ☐
If yes	when	
	duration (in weeks)	
	Boat type:	
	If sunfish were they able to sail solo?	Yes ☐ No ☐

Can you child swim 50 ft. without a swim aid?	Yes ☐ No ☐

Payment and completed registration forms (including medical and emergency contact sections) are required before student is accepted into the program. Classes fill up fast, so it is best to get your registration in at least two weeks in advance.

SEND TO:	**Program questions?**
P.O. Box 931 Pentwater, MI 49449	Sue Bainton 284 E. Lowell St. Phone: (231) 923-8888 Email:wsbainton@aol.com

_____ _____

Signature of parent (or legal guardian) Date

By signing this registration the parent or legal guardian acknowledges that the Pentwater Junior Sailing Program is a non-profit, charitable 501(c3) organization, and participants enter program at their own risk, and will not hold the Pentwater Junior Sailing Program, it's Board of Directors, or the Village of Pentwater liable for any reason.

Pentwater Junior Sailing Program
Medical & Emergency Information

This form must be completed and signed by the legal guardians of the student before he/she can participate in the program. In case of an emergency this form will accompany the student to the hospital.

Last Name: _____ First Name: _____

DOB: _____ Sex _____

Sex: _____ Weight: _____ Height: _____

Needed to determine crew assignments

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name	Relation
Home phone	Work phone

Name	Relation
Home phone	Work phone

MEDICAL INFORMATION

Do you currently have a history of, or do you currently have any physical limitations that might prevent you from fully participating in this course Yes ☐ No ☐

If yes, please check those that apply or specify if other.

Chronic Ailments:

- Asthma or other respiratory problems ☐
- Circulatory or Heart problems ☐
- Diabetes or Hypoglycemia ☐
- Epilepsy ☐
- Hemophilia, or other bleeding problems ☐
- Other _____

Allergies:

- Insect bites ☐
- Bee stings ☐
- Foods ☐
- Other _____

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MEDICAL INFORMATION CONTINUED

Do you have any learning disability that might prevent you from fully participating in this course	Yes ☐ No ☐
If yes, please specify	

Are you currently taking any Medications	Yes ☐ No ☐
If yes, please list:	

Blood type (optional) _____

Date of last tetanus shot _____

Family Physician _____

Phone # _____

Date of last physical examination: _____

Insurance carrier: _____ Insurance ID: _____

I, the undersigned, do hereby authorize to any consent to an ex-ray, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or dentist licensed under the provision of the Education Law and/or Public Health Law of the State of Michigan. And on the staff of any Hospital holding a current operating certificate issued by the Department of Health of the State of Michigan. 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 which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that efforts shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be with held if any of these people cannot be reached.

_____ _____

Signature of parent (or legal guardian) Date