

**COST OF PROGRAM IS \$100.00 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: \_\_\_\_\_

Is your child a student at Pentwater Public Schools?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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### **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 July 1 thru August 9**  
**Children 12 years and under must take two weeks in the Prams (beginners).**

Week you would like to start 1 <sup>st</sup> Preference	
2 <sup>nd</sup> Preference	
3 <sup>rd</sup> Preference	

Has your child been in the Sailing Program before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If yes</b>	
How many weeks have they sailed Prams?	
How many weeks have they sailed Sunfish?	
If sunfish were they able to sail solo?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Can your child swim 50 ft. without a swim aid?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Payment and completed registration forms (including medical and emergency contact sections) are required before student is accepted into the program. Classes fill up fast.

<b>SEND TO:</b>	<b>Program questions?</b>
P.O. Box 931 Pentwater, MI 49449	Phone: (231) 923-8888 Email: pam.slotsema@gmail.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 <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	

Are you currently taking any Medications	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 withheld if any of these people cannot be reached.

\_\_\_\_\_  
Signature of parent (or legal guardian)

\_\_\_\_\_  
Date