

## 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 3 thru August 11**  
**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	
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Has your child been in the Sailing Program before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>If yes</b>	when	
	duration (in weeks)	
	Boat type:	
	If sunfish were they able to sail solo?	Yes <input type="checkbox"/>

Can you child swim 50 ft. without a swim aid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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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.

<b>SEND TO:</b>	<b>Program questions?</b>
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 <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 with held if any of these people cannot be reached.

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

\_\_\_\_\_  
Date