



KE KAI O'UHANE OUTRIGGER CANOE CLUB

Emergency Contact Form (Paddlers)

MEMBER'S INFORMATION:

(Please print)

First Name: _____ Last Name: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Contact #1:

1. Name: _____ Relationship: _____
 2. Address: _____ City: _____ Zip: _____
 3. Home Phone: _____ Work Phone: _____

Contact #2:

1. Name: _____ Relationship: _____
 2. Address: _____ City: _____ Zip: _____
 3. Home Phone: _____ Work Phone: _____

Family Physician:

Name: _____
 Phone: _____

Hospital:

Name: _____
 Address: _____

Insurance Carrier: _____ Policy/Group No. _____

ILLNESSES/ALLERGIES:

Chronic or Recurring Illness:

Ear Infection Bleeding/Clotting Disorders Hypertension Asthma
 Seizures Musculoskeletal Disorders Heart Defect/Disease Diabetes
 Other (specify) _____

Allergies:

To the best of my knowledge, unless specifically stated below, the above listed member has no allergies to medications, anesthetics or X-rays.

The above listed member is allergic to the following: _____

 Your Printed Name or that of Parent or Guardian

 Your Signature or that of Parent or Guardian

 Date

(Please fill out the back of this form if member is a minor).

AUTHORIZATION OF TRANSPORTATION OF MINOR CHILD

I give my permission to **ALL** responsible adult members of Ke Kai O'Uhane Outrigger Canoe Club to transport my child as listed herewith, _____ to and from practice, regattas, club related events and/or activities, when I am unable to supply transportation.

Printed Name of minor child

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

AUTHORIZATION OF CONSENT TO TREATMENT OF MINOR CHILD

PARENT/ADULT CONSENT: In the event of an emergency, every effort will be made to contact a parent or emergency contact. If no contact can be made, I hereby give authorization to Ke Kai O'Uhane Outrigger Canoe Club to seek treatment for my child or myself by a licensed physician under the Medical Practice Act, pursuant to Section 25.8 of the California Civil Code.

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 on the part of my aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

Signature of Parent/Guardian/Adult

Date

Minor child entrusted in this authorization:

Printed Name of Child

Birth Date

