

Sequim Bay Yacht Club

Post Office Box 1261
Sequim, Washington 98382

Approved: _____ Date: _____

Membership _____

Committee: _____

Board: _____

Rejected: _____

JUNIOR MEMBERSHIP APPLICATION

Name: _____

Address: _____
_____ (1)

Date of Birth: _____ Sponsor/s _____ (2)

Phone: _____ Signature: _____

Hobbies: _____

Email address: _____

Dues: \$25 per year - make check payable to Sequim Bay Yacht Club (or SBYC)

Please send this application with check to: Jean and Rudy Heessels
253 Greywolf Road
Sequim WA 98382

PARENTS SIGNATURE _____

STATEMENT OF UNDERSTANDING

(This sheet must be completed prior to participating in Sequim Bay Jr Yacht Club activities)

Sailing is an exciting and demanding challenge, but you need to be aware of what will be involved and be willing to study and practice in order to achieve success and receive maximum benefit from Sequim Bay Jr Yacht Club activities.

A swim check is required of all participants and members. The check consists of swimming 50 yards in sailing clothes and shoes. The medical information form must be completed and signed by you or a parent or legal guardian and turned in prior to participating in Sequim Bay Jr Yacht Club activities.

You will be required to provide your own Type III personal flotation device (PFD). The PFD must be Coast Guard approved and the proper size for your weight and build. It should be comfortable, since you will be wearing it at all times while you are on or near the water. You must wear shoes at all times while you are in the boats, on the piers, or in the boat launching area. Bring a change of clothes and a towel each day.

Please carefully read and sign the following agreement, if you are under 18 have your parents read and sign the second agreement.

I understand that in enrolling and participating in Sequim Bay Jr Yacht Club activities, I agree to obey all program rules as set forth by the adult advisors. I agree that I will use utmost care in the use of the boats and equipment. I understand that if I fail to attend regularly, arrive promptly, and abide by the rules, I may be suspended from the program.

Student Name (please print)

Student Signature

Date

Parental Agreement

I/We understand the contents of this Agreement. I/We agree to see to it that my/our child adheres to the program rules. I/We agree to assume the obligation of the expenses of repair and/or replacement of program equipment whose loss or damage is attributable to my/our child's reckless or irresponsible behavior.

Further, in consideration for my minor child being permitted to participate in Sequim Bay Jr Yacht Club activities, I/we agree that I/we will not make any claim, either for ourselves or on behalf of my/our child, against the Sequim Bay Yacht Club, its representatives, the Jr Yacht Club adult advisors, or against the host organization or its officers, or members, for any personal injuries or wrongful death to such child, or for damage to any of the child's property, arising out of the activities of this course.

Parent/Guardian Name (please print)

Parent/Guardian Signature

Date

MEDICAL AND EMERGENCY INFORMATION

(This sheet must be completed prior to participating in Sequim Bay Jr Yacht Club activities)

NAME _____ SEX ___(M) ___(F)

ADDRESS _____

X Street/P.O. Box City State Zip

TELEPHONE (R) _____ (B) _____ DATE OF BIRTH _____

PHYSICAL DISABILITIES (Please specify missing or injured body parts, weakness, eyeglasses, contacts, hearing aids, etc.) _____

Please check (X) those that apply: (Provide any necessary details on additional sheet.)

CHRONIC AILMENTS:	ALLERGIES:
ASTHMA, OR OTHER RESPIRATORY PROBLEMS	MEDICATION
DIABETES OR HYPOGLYCEMIA	BEE STINGS/INSECT BITES
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	FOODS
CIRCULATORY OR HEART PROBLEMS	OTHERS, IF SIGNIFICANT
EPILEPSY	

DATE OF LAST TETANUS SHOT _____ BLOOD TYPE _____

CURRENT MEDICATIONS IF ANY: _____

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. 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 best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER

SIGNATURE OF APPLICANT: _____ DATE: _____

If over 21, Signature of Participant; If under 21, Signature of Father, Mother or Guardian