

GUST



EVENT & COACHING REGISTRATION

Event Dates: _____ Location: _____

Sailor's Name: _____

Date of Birth: _____ Sex: _____ Type of Boat: _____

Address: _____ City/State/Zip: _____

Email Address: _____

Home Phone: _____ Mobile Phones: _____

Is housing needed? YES NO

(Please note that housing requests must be received 1 week prior to event)

GUST/Racing Team Member FREE

OR

Non-Gust Participant Fee \$30/day _____

Make checks payable to the hosting club & mail to that club's address:

NSA

c/o Vic Carter

550 S Turquoise

Wichita, KS 67209

OCBC

c/o Kevin Smith

428 NW 17th

Okla. City, OK 73103

WSC

c/o Lisa Weatherholt

4833 S. Lewis Place

Tulsa, OK 74105

Medical Consent Form And Participant Fees Must Be Included

LIABILITY RELEASE AGREEMENT

IN CONSIDERATION OF ACCEPTANCE OF MY CHILD'S REGISTRATION TO PARTICIPATE IN THE GUST PROGRAM AND, RECOGNIZING THE RISKS ASSOCIATED WITH THE SPORT OF SAILING, THE UNDERSIGNED HEREBY WAIVES ALL CLAIMS FOR PERSONAL INJURY AND PROPERTY DAMAGE AND HEREBY RELEASES CSSA, THE GUST ASSOCIATION, THE HOST CLUB AND THEIR DIRECTORS, OFFICERS, MEMBERS, EMPLOYEES, AND VOLUNTEERS AND SPONSORS, OF AND FROM ANY AND ALL CLAIMS, INCLUDING THOSE OF NEGLIGENCE AND GROSS NEGLIGENCE, WHICH I OR MY CHILD MIGHT HAVE, ARISING OUT OF MY CHILD'S PARTICIPATION IN THE PROGRAM AND ALL ACTIVITIES RELATING THERETO.

Parent/Guardian's Signature: _____ Date: _____

GUST



MEDICAL CONSENT

NAME OF PARTICIPANT: _____ **AGE:** _____

NAME OF PARENT/GUARDIAN (printed): _____

HOME ADDRESS: _____

PHONE NUMBERS:

HOME: _____ **CELL:** _____

WORK: _____ **OTHER:** _____

In the event of accident, injury or illness involving any child of mine (specifically including my child named above as the "Participant") or me or my spouse while in, on, or about the premises of a GUST contributing club (the "Club") or while participating in any activity sponsored by or under the auspices of said Club under circumstances where I am physically unable to consent or am not present,

1. I hereby voluntarily authorize and consent to the furnishing to myself, my spouse, or any child of mine of such medical care, attention, and treatment by any hospital, physician or dentist as such hospital, physician or dentist may deem necessary or advisable, including any x-ray examination, anesthetic, medical, or surgical diagnosis or procedure.
2. I authorize any adult associated with the activity to consent to such medical care, attention and treatment.
3. I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost the assisting adult, the Club, GUST, CSSA, and the officers, employees and members of said organizations.

It is understood that every 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.

ALTERNATIVE PERSONS TO CONTACT:

NAME	RELATIONSHIP	PHONE NUMBER
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PRIMARY CARE PHYSICIAN:

NAME	PHONE NUMBER
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ATTACH COPY OF HEALTH INSURANCE CARD, OR COMPLETE THE FOLLOWING:

HEALTH INSURANCE CARRIER	INSURANCE ID NO.	NAME OF INSURED
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PHONE NO. FOR VERIFICATION	CLAIMS MAILING ADDRESS
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I agree that a photocopy of this consent or a copy sent by facsimile may be accepted by any health care providers. This consent shall be valid for one (1) year from the date of signing.

SIGNATURE OF

PARENT/GUARDIAN: _____ **DATE:** _____