REGATTA REGISTRATION FORM
Central States Sailing Association Jr. Circuit

CSSA Championship Regatta 2014-Ninnescah Sailing Association

Competitor: _____ Club: _____

Address: City/State: _____Zip: _____

Telephone: _____ Cell: _____ Birth date: _____

Circle your Fleet: Laser (Rig) _____ Club 420 Sunfish Catamaran
Optimist Green (Novice) Optimist Red (Experienced)

Sail Number: _____Crew's Name: _____

Email Address: _____

T-shirt Order*: cost included in fees, please circle correct size*: YS YM YL AS AM AL AXL

Regatta Fees *$15.00*: _____

Extra shirts may be ordered at $12 each
Sizes and number of shirts to order:
YS___ YM___ YL___ AS___ AM___ AL___ AXL___

Extra T-Shirts@$10_____

Non-competitor Meals:
Lunch @ $2 _____
Dinner @ $3 _____

Total: $_____
Make checks payable to:
Ninnescah Sailing Association - NSA

CSSA Membership $15 Family, $10 Individual: $_____
(Membership is required to compete. If not already a member, please pay separately.)

LIABILITY RELEASE AGREEMENT
IN CONSIDERATION OF ACCEPTANCE OF MY CHILD'S REGISTRATION TO PARTICIPATE IN THE REGATTA 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 THE CENTRAL STATES SAILING ASSOCIATION, THE HOST CLUBS AND THEIR DIRECTORS, OFFICERS, MEMBERS, EMPLOYEES, AND THE REGATTA 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 REGATTA AND ALL ACTIVITIES RELATING THERETO.

Parent/Guardian's_____

Signature: _____Date:_____

CSSA
MEDICAL CONSENT FORM

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

NAME OF PARENT/GUARDIAN (printed): _____

HOME ADDRESS: _____

PHONE NO: _____ **CELL PHONE**: _____

E-MAIL:_____

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 Central States Sailing Association ("CSSA") member yacht 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, CSSA and the officers, employees and members of said organizations. 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.

ALTERNATIVE PERSONS TO CONTACT:

_____

NAME RELATIONSHIP PHONE NUMBER

PRIMARY CARE PHYSICIAN:

_____

NAME PHONE NUMBER

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

_____

HEALTH INSURANCE CARRIER INSURANCE ID NO. NAME OF INSURED

_____

PHONE NO. FOR VERIFICATION CLAIMS MAILING ADDRESS

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:**

_____ _____