

Skaneateles Country Club Sail School 2010  
PO Box 29  
Skaneateles, NY 13152  
315-685-5759



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## Private Lesson Registration

**Student Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birthday** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone: Home:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell/Pager:** \_\_\_\_\_

**Email(s):** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

\_\_\_\_\_ **Phone:** \_\_\_\_\_

**Please answer these questions:**

What boating, sailing and on the water experience have you had?

If you have a personal goal for sailing lessons what is it?

When do you hope to take your private lesson(s)? (morning, afternoon, evening, weekend)

*Private lessons are \$40/hour. Once we have received this we will call to schedule a lesson(s) and will assign you to an available instructor.*

**To complete your registration** send this (2 page) form with your payment to: SCC Sail School, PO Box 29, Skaneateles, NY 13152 or deliver to the Focsle attn: Janice Wiles Payment: either by check payable to Skaneateles Country Club or charge to member account

Refer all questions to Janice Wiles, Director (240 626 5209 email: [sccsailschool@gmail.com](mailto:sccsailschool@gmail.com)) or the Country Club Office (315 685-5759)

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Check #: \_\_\_\_\_ Member Account Name: \_\_\_\_\_ Date: \_\_\_\_\_

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### Medical Information and Authorization

To ensure the safety of your children when involved in the Skaneateles Country Club Sail School each parent/guardian must fill out this form for each registered child. This form will be filed in the SCC Sail School office, located in the Foc'sle, as well as in the club main office. This form will accompany any child while participating in any Sail School activity off the club grounds, i.e. racing class students.

#### Medical Information:

- Student's Name \_\_\_\_\_
- Allergies: \_\_\_\_\_
- Type of reaction: \_\_\_\_\_
- Treatment Required: \_\_\_\_\_
- Special Needs/conditions: \_\_\_\_\_
- Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Emergency Contact \_\_\_\_\_ Relationship: \_\_\_\_\_
- Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_
- Health Insurance Carrier: \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### Medical Authorization:

The undersigned parent/guardian of \_\_\_\_\_ a minor, does hereby authorize the SCC Sail School Staff to act in my absence to authorize or consent to any emergency X-ray, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act. It is understood 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 our aforesaid agent(s) 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; and neither said agent or any organization involved assumes any financial responsibility for exercising this action.

This authorization shall remain effective until revoked, in writing.

Signature: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_