SP#5 Ransom Everglades School
Saturday February 10th, 2024
3575 Main Hwy, Coconut Grove, FL 33133
305 460 4359

1. **School Data:**

School's Name: _____

Address: _____

Town/City: _____ State: _____ Zip Code: _____

ISSA District: _____

2. **Projected Team Roster** Eight max, including alternates. Roster may be changed at registration.
Please fill out one copy of the waiver below for each competitor.

Name:	Graduation Year:	Name:	Graduation Year:
1.		_____	
6._____			
2.		_____ 7.	
_____			
3.		_____	
8._____			
4.		_____	
5. _____			

3. **Contact/ Chaperon/ Coach Information:**
Team Contact (Traveling with team), Coach (If you will have one with you):

_____

Cell Phone: (____) _____ E-Mail: _____

4. **Food:** Teams bring lunch.

5. Entry fee and Damage deposit:

Entry fee $75.00 per varsity and JV teams as prescribed in the Notice of Race. Make both checks payable to: **Ransom Everglades School**

Rev:June 2010

Sailor Name: _____ School Name: _____

WAIVER OF LIABILITY/RELEASE OF RISK
INTERSCHOLASTIC SAILING ASSOCIATION (ISSA)
2024 SAISA SOUTH POINTS SERIES #5 RANSOM EVERGLADES SCHOOL

As the parent/guardian of the above named student, I hereby acknowledge that Sailing is an activity that has an inherent risk of damage and injury. Competitors in this event are participating entirely at their own risk. See RRS 4, Decision to Race. The ISSA and race organizers (**organizing authority, race committee, host club, sponsors, or any other organization or official)** will not be responsible for damage to any boat or other property or the injury to any competitor, including death, sustained as a result of participation in this event. By participating in this event, each competitor agrees to release the ISSA and race organizers from any and all liability associated with such competitor's participation in this event to the fullest extent permitted by law.

Date: _____

Signature: _____

Print Name: _____

Relation to Named Student: _____

Rev:May2006
Review June 2010

Sailor Name: _____ School Name: _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

The undersigned parent or guardian of a minor does hereby consent to emergency X-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, or dentist under the Dental Practice Act. It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgment may deem advisable. It is understood that efforts shall be made to contact the undersigned or Emergency Contact prior to rendering treatment, but treatment will not be withheld if they cannot be reached.

1. Family Doctor: _____ Phone: _____

2. Emergency Contact: _____ Phone: _____

3. Medical Problems: _____

4. Known Allergies: _____

5. Hospital Insurance Plan Name/Number: _____
_____

SIGNATURE (Parent or Legal Guardian): _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Phone (h): _____ (w): _____ (c): _____

Father's Phone (h): _____ (w): _____ (c): _____