



# HOMESCHOOL SAILING REGISTRATION FORM

***Both pages of form must be returned with signature.***

Date & Time: \_\_\_\_\_

Cost Enclosed \$ \_\_\_\_\_

Member Number: \_\_\_\_\_

Mystic Seaport Member?     Yes     No

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Parent (Guardian) Name \_\_\_\_\_

The persons listed above have permission to pick-up my child \_\_\_\_\_

## Medical Information

Chronic or recurring illness (ie. heart problems, Diabetes) \_\_\_\_\_ Allergies \_\_\_\_\_

Medication(s) taken (name and reason) \_\_\_\_\_ Injuries or special restrictions \_\_\_\_\_

In case of emergency, contact the following person and/or physician:

Emergency Contact #1 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Phone #2 \_\_\_\_\_

Emergency Contact #2 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Phone #2 \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone \_\_\_\_\_

## Method of Payment

Cancellations made up to 30 days prior to the start of a course will receive a refund less an administrative fee of 25% of the course cost. Cancellations made 15 to 29 days prior to a class will receive a refund less an administrative fee of 50% of the course cost. No refund will be given if cancelled within 14 days of the course.

Check is enclosed    Please charge my:     VISA/MC     AMEX     DISCOVER

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Total Amount \$ \_\_\_\_\_ Name of Cardholder \_\_\_\_\_

***Don't forget page 2!***



# HOMESCHOOL SAILING REGISTRATION FORM – 2

***Both pages of form must be returned with signature.***

Date & Time: \_\_\_\_\_

\_\_\_\_\_  
Name Age

### Permission

I certify that \_\_\_\_\_ is a competent swimmer, that this health history is correct and complete to my knowledge and therefore give permission for my son/daughter to participate in all program activities — except where noted. If I cannot be reached, in the event of an emergency, I authorize Mystic Seaport to seek, provide and consent to any emergency medical or dental treatment, including but not limited to the administration of prescribed medication, related transportation, hospitalization, injections and anesthesia for surgery.

\_\_\_\_\_  
Signature Date

### Statement of Responsibility

In the event of illness or an accident, I authorize Mystic Seaport to initiate appropriate medical or dental treatment on my behalf or that of my child(ren) if I am unable to do so. I understand, except in the case of negligence, that I am not covered under Mystic Seaport’s insurance and that I am responsible for payment of all medical or dental treatments received. Further I indemnify Mystic Seaport, its agents and employees from any complications or issues that may arise from such treatment.

\_\_\_\_\_  
Signature Date

Occasionally Mystic Seaport photographs or videotapes visitors while on grounds for use in a variety of publicity and promotional materials and to advance our educational mission. We thank you for your cooperation and support.

**For information on all programs, call 860.572.5322 or email [reservations.desk@mysticseaport.org](mailto:reservations.desk@mysticseaport.org).  
Please complete and return registration form by mail to Reservations, Mystic Seaport, PO Box 6000, Mystic, CT 06355,  
by fax to 860.572.5398 or by email using the button below.**

*Forms requiring signature or additional information from a healthcare provider may be submitted by email.  
Follow up with signature and documentation will be required.*

**SUBMIT**