



Health Registration Form

Full Name: _____ Birth Date: _____

Address: _____ Phone: _____

City: _____ State: ____ Zip: _____

Parent's/Guardian's Name: _____ Phone: _____

Street Address: _____
(If different from youth's)

City: _____ State: ____ Zip: _____

Emergency Contact: _____ Phone: _____
(If parent's or guardian's cannot be reached)

List communicable diseases and past history of serious lacerations, injuries and illnesses:

List any known allergies and drug reactions:

List any prescriptive or non-prescriptive medications which youth must take:

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Prescribing Physician</i>
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Describe any special diets youth must follow:

<i>Description of diet</i>	<i>Prescribing Physician</i>
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Attach Certificate of Immunization or complete the following:

<i>Vaccine</i>	<i>Month and Year</i> (Each immunization was given)
Diphtheria-Tetanus-Pertussis (DTP or baby shots) Or Tetanus-Diphtheria (DT)	_____
Polio	_____
Measles (hard, red)	_____
Rubella (German measles)	_____
Mumps	_____
Other: _____	_____

Date of last physical examination: _____

Physician's Name: _____ Phone: _____

Authorization to participate or exclude participation in event activities:

I _____ give permission for my child to participate in all even activities with the following exceptions:

Authorization for medical care:

I hereby give my permission to event officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____, should an emergency arise. It is understood that event officials will make a conscientious effort to locate the emergency contacts listed in this document before any action will be taken. If it is not possible to locate emergency contacts listed, I/we will accept the expense of emergency medical or surgical treatment.

Insurance Company: _____ Policy #: _____

Subscriber Name: _____

Address: _____
City State Zip

Parent's or Guardian's Signature: _____