EMERGENCY AND HEALTH INFORMATION:

Participant's Full Name:_____ Date of Birth: _____

If I cannot be contacted at any of the phone numbers listed below, I give consent for the administration of any treatment deemed necessary by Physician or Dentist as listed below under Medical Information. If the designated Physician or Dentist is not available, I give consent for the administration of treatment deemed necessary by another licensed physician or dentist. If hospitalization is necessary, I give consent to transfer my child to a hospital. Preferred hospital:_____

1. Parent/Guardian/Custodian with Whom Participant Resides:

Name: _____ Relationship to participant: _____
Address: _____
Cell Phone: _____ Home Phone: _____
Employer: _____ Work Hours: _____
Work Phone: _____ Email Address: _____

2. Medical Information:

Physicians name: _____ Dentist name: _____
Street address: _____ Street address: _____
City, State: _____ City, State: _____
Phone #: _____ Phone #: _____

Date of Last Tetanus: _____

Known Allergies: _____
_____

Present Medications: _____

Are there any Conditions which could limit participation or result in an emergency situation? _____
_____

Other Medical Information we should be aware of: _____
_____

Insurance Company: _____ Policy Holder's I.D. _____

Signature of Parent/Guardian: _____ Date: _____