PARTICIPANT

Name: _____Date of Birth:___/____/____ Male ☐ Female ☐

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell:_____Email:_____

PARENT OR LEGAL GUARDIAN INFORMATION

Parent/Guardian Name: _____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell:_____Work Phone:_____

Email:_____Does participant live with you? Yes ☐ No ☐

Parent/Guardian Name: _____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell:_____Work Phone:_____

Email:_____Does participant live with you? Yes ☐ No ☐

In case parent(s)/legal guardian cannot be reached in an emergency, contact:

Name:_____Phone:_____Relationship to Participant:_____

Name:_____Phone:_____Relationship to Participant:_____

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (ie EMT, First Responder, ER physician). Signature:_____

Family Doctor:_____ Phone:_____

Address:_____City:_____State:_____

HospitalPreference:_____

Parent Insurance Carrier:_____Policy No._____Group ID:_____

Please list any allergies and/or medical problems, include those requiring regular medication (ie Diabetes, Asthma, Seizure Disorder).

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster:_____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Authorized Parent/Guardian signature:_____Date:_____