MEDICAL INFORMATION

Name_____ **Home phone:(_____)**_____

Cell phone(s)_____

Address_____

D.O.B._____ **Age**_____ **Parent's work phone:(_____)**_____

Parent(s) name(s)_____ **email:**_____

Emergency contact/Neighbor_____ **phone:(_____)**_____

Recent surgery/illness_____ **Date**_____

Asthma/other limiting conditions_____

Any known allergy to medication_____

Childhood diseases_____

Date of last tetanus shot_____ **Home physician**_____

Address_____ **phone:(_____)**_____

Medication to be taken/dosage_____

for the following condition_____

****Major medical insurance carrier**_____

Insurance billing address_____

Subscriber name_____

Subscriber employer & policy #_____

****Each participant must provide their own major medical coverage. There is no medical coverage provided as part of this program.**

Please note: Please read & sign indemnification agreement on the back.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize that medical and/or surgical care be provided for my child. I assume all financial responsibility for this care.

Signature_____ **Relationship**_____ **Date**_____

Guardian (Please Print)_____

Additional information_____

REMINDERS: Are there any blank spaces on this form? Please complete.
A parent must sign front & back if you are under 18.