

Medical Information

Participant's Name: _____

Address: _____

Birth Date: _____

Recent Illness: _____

Does your child have any:

Skin disease: _____

Lung trouble: _____

Heart trouble: _____

Allergies: _____

If yes, explain: _____

Does your child require medication? _____

If yes, explain: _____

Date of last tetanus shot: _____

In case of emergency notify:

First Contact:

Name: _____ Phone: _____

Second Contact:

Name: _____ Phone: _____

Insurance Information:

Insurance Company: _____

Policy/Group Number: _____

Parents/and or Guardian signature: _____ Date: _____