Health Registration Form

Name of Event: Date of event: to:

Legal Name: Birth date:

Home Address: Phone:

City: State: Zip:

Parent's or Guardian's Name:

Street address: Phone:
(if different from child's)

City: State: Zip: Cell Phone:

Place of employment: Phone:

If neither parent nor guardian can be located, in case of emergency call:
(Include name and phone number)

Persons designated to take child from event:
(Include name, address and phone if not listed above)

Persons not permitted to take child from event:

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:

Name of Medication *Dosage* *Frequency* *Prescribing Physician*

Describe any special diets youth must follow:

Description of diet *Prescribing physician*

Youth must have had a physical examination within the preceding 24 months by a licensed physician or a licensed nurse practitioner. The event has the right to refuse admission of a youth who does not have examination verification.

Date of last physical examination:

Physician's Name: Phone:

Attach Colorado Certificate of Immunization or complete the following:

Vaccine	*Month and year* *Each immunization was given*
Diphtheria-Tetanus-Pertussis (DTP or baby shots) Or Tetanus-Diphtheria (TD)	
Polio	
Measles (hard, red)	
Rubella (German measles)	
Mumps	
Other	

Authorization to participate or exclude participation in event activities: I give permission for my child to participate in all event 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 on 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 and address:

Parent's or Guardian's signature:_____ Date:_____