Health Registration Form

Name of Event: _____ Date of event: _____

Legal Name: _____ Birth date: _____

Home Address: _____ Phone: _____

City: _____ State: CO Zip: _____

Parent's or Guardian's Name: _____

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

City: _____ State: CO Zip: ____ Cell Phone: _____

Place of employment: _____ Phone: _____

If neither parent or 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: _____

Do you have any medical condition that may limit your ability to participate in this event without accommodation? If so, please explain the nature of your condition and any accommodation requested. Do you have any allergies, or drug reactions or special dietary needs we should be aware of? If so, please explain:

_____

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/year 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: _____