

**Health/Registration Form**

Name of Event: \_\_\_\_\_

Name: \_\_\_\_\_ Date of event: \_\_\_\_\_ to \_\_\_\_\_

Home address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
street

\_\_\_\_\_ Birth date: \_\_\_\_\_  
city state zip

Parent's or Guardian's name: \_\_\_\_\_

Home address: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_  
(if different from child's) street

\_\_\_\_\_ Birth date: \_\_\_\_\_  
city state zip

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 nonprescriptive medications which youth must take:

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Prescribing Physician</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 an examination verification.

Date of last physical examination: \_\_\_\_\_

Attach Colorado Certificate of Immunization or complete the following:

<i>Vaccine</i>	<i>Month and year each immunization was given</i>
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: \_\_\_\_\_



