



Emergency Contact Information

Primary contact: _____ Relation: _____

Address: _____ Email: _____

Home phone: _____ Cell phone: _____

Alternate contact: _____ Relation: _____

Address: _____ Email: _____

Home phone: _____ Cell phone: _____

Medical Insurance: _____

Policy number: _____ Telephone: _____

Family doctor: _____

Food/Other Allergies? Yes No

Current Medications? Yes No

Dietary Restrictions? Yes No

Physical Limitations? Yes No

Are there other health issue you would like to mention? Yes No

Participant Signature _____ Date: _____

Parent Signature _____ Date: _____