

**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 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:

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:

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Prescribing Physician</i>
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Describe any special diets youth must follow:

<i>Description of diet</i>	<i>Prescribing physician</i>
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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:

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: \_\_\_\_\_