APPLICATION / REGISTRATION FORM

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT'S NAME (LEGAL GUARDIAN) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (____) _____ - _____

EMERGENCY PHONE # _____ CONTACT'S NAME _____

INSURANCE COMPANY_____ POLICY # _____

HEALTH INFORMATION (CIRCLE THOSE APPROPRIATE)

Down Syndrome	**Atlanto-axial Instability**	**Diabetes**
Heart Problems	**Seizure Disorder**	**Visually impaired**
Hearing impaired	**Fainting spells**	**Non-verbal, signs**
Hepatitis	**Bleeding Problems**	**Mobility impairment**
Asthma	**Emotional Problems**	**Learning disabilities**
Allergies	**High Blood Pressure**	**Low Blood Pressure**

OTHERS: please list

_____

LIST AIDS USED (such as a wheelchair, hearing aid, glasses etc.)

_____

_____

LIST ALLERGIES

_____

_____

MEDICATIONS:

NAME	**DOSEAGE**	**TIME GIVEN**	**SIDE EFFECTS**

_____

_____

_____

IMMUNIZATIONS:

	DATE OF LAST SHOT
TETANUS	_____
POLIO	_____
HEPATITIS B	_____

LIST ANY OTHER INFORMATION THAT THE COACHING STAFF NEEDS TO KNOW ABOUT YOUR CHILD.

_____

_____