Health Profile

Name ________________________________ Date of Birth __________

Medical concerns: (any condition we should be aware of)

Medications:

Allergies: (food, medication, bee stings, etc.)

Activity restrictions: (swimming, heights, etc)

Home phone: ___________________
Emergency contacts ____________________________
Phone #s ____________________________

If applicable:
Parent contact – Name: _______________
Home: ________ Cell: ______________ Work: ______________

Parent contact – Name: _______________
Home: ________ Cell: ______________ Work: ______________

Insurance Policy # ____
Please attach a copy of your insurance card to this form.

In case of a medical emergency, the participant will be given necessary medical treatment at the nearest hospital, ER, or clinic and the parent and/or emergency contact will be contacted as soon as possible.