



## 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 contact:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**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.**