



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.