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.