

**Health Registration Form**

Name of Event: \_\_\_\_\_ Date of event: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: CO Zip: \_\_\_\_\_

Parent's or Guardian's Name: \_\_\_\_\_

Street address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(if different from child's)

City: \_\_\_\_\_ State: CO Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Phone: \_\_\_\_\_

If neither parent or guardian can be located, in case of emergency call: \_\_\_\_\_  
(include name and phone number)

Persons designated to take child from event: \_\_\_\_\_  
(include name, address and phone if not listed above)

Persons not permitted to take child from event: \_\_\_\_\_

Do you have any medical condition that may limit your ability to participate in this event without accommodation? If so, please explain the nature of your condition and any accommodation requested. Do you have any allergies, or drug reactions or special dietary needs we should be aware of? If so, please explain:

\_\_\_\_\_

Youth must have had a physical examination within the preceding 24 months by a licensed physician or a licensed nurse practitioner. The event has the right to refuse admission of a youth who does not have examination verification.

Date of last physical examination: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Attach Colorado Certificate of Immunization or complete the following:

***Vaccine***

***Month/year immunization was given***

Diphtheria-Tetanus-Pertussis (DTP or baby shots)

or

Tetanus-Diphtheria (TD)

\_\_\_\_\_

Polio

\_\_\_\_\_

Measles (hard, red)

\_\_\_\_\_

Rubella (German measles)

\_\_\_\_\_

Mumps

\_\_\_\_\_

Other

\_\_\_\_\_

*Authorization to participate or exclude participation in event activities:* I give permission for my child to participate in all event activities with the following exceptions:

\_\_\_\_\_

*Authorization for medical care:* I hereby give my permission to event officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, \_\_\_\_\_, should an emergency arise. It is understood that event officials will make a conscientious effort to locate the emergency contacts listed on this document before any action will be taken. If it is not possible to locate emergency contacts listed, I/we will accept the expense of emergency medical or surgical treatment.

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber Name and address: \_\_\_\_\_

Parent's or Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_