TEAM2FOUR

SKILLS CLINIC PARTICIPANT REGISTRATION FORM

(Sign and return)

Parent Name: ____

Address:____

City: ____ State: ______ Zip:____________________

Primary Phone: __________________________Secondary Phone:______________________________

Email address: ____________________________________

Minor Participant Name:______________________________Gender: _______ Age: ________________

Birth Date: ________________ School __________________________ Grade (as of 9/2013)__________

Email___________________________ phone __________________________

List any medications participant will take while participating in this program (*Note: Team 2Four will not be dispensing any medications*):

____

List any physical conditions that may affect or limit full participation in any of the activities or any special medical conditions (e.g., food allergies, ADHD, asthma, cancer, leukemia, diabetes, heart condition, etc.) that we should be aware of:

____

List medical devices customarily used, if app. (wheelchair, braces, glasses, contact lenses, hearing aid, etc.):

____

Emergency Contact:

In case of an emergency, please call: ____________________ (relationship: _____________)

Phone: _________________

I have provided all the above information honestly and to the best of my knowledge, and have read and understand the clinic attendance requirements and disciplinary code and agree to adhere to both at all times.

Participant Signature: ____Date_____:__________

Parent Signature: ____Date:_______________