

Woo Skate Club – Registration

Health Information & Emergency Medical

Child's Name: _____ Date of Birth ____/____/____ Sex: M / F Age: _____

Child's Name: _____ Date of Birth ____/____/____ Sex: M / F Age: _____

Child's Name: _____ Date of Birth ____/____/____ Sex: M / F Age: _____

Home Address: _____ Phone: _____
City Zip

① Parent/Guardian: _____ Address: _____

Phone # _____ E-mail: _____

② 2nd Parent/Guardian: _____ Address: _____

City Zip

Phone # _____ E-mail: _____

Emergency contacts between 3:00 pm and 6:00

Name: _____ Phone #: _____

Name: _____ Phone #: _____

HEALTH HISTORY

Please check if your child has had or does have any of the following:

	<u>Diseases</u>	<u>Allergies</u>
____ Frequent Ear Infections	____ Chicken Pox	____ Hay Fever
____ Heart Defect/Disease	____ Measles	____ Poison Ivy
____ Convulsions	____ German Measles	____ Insect Stings
____ Diabetes	____ Mumps	____ Penicillin
____ Bleeding/Clotting Disorders	____ Asthma	____ Other Drugs or Food(s):
____ Hypertension Mononucleosis		_____
____ Psychiatric Treatment		_____

Operations/broken bones/serious injuries (please describe and give dates): _____

Disability or chronic/reoccurring illness: _____

Medication(s): _____ For what Condition(s): _____

Instructions for Medication(s): _____

Would you like your child to wear a helmet when skating? _____

Would you like your child transported in a booster seat? _____

What school is your child attending? _____ Self transport: _____

Days attending (circle all that apply) Monday Tuesday Wednesday Thursday Friday
