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

❶ Parent/Guardian:_____ Address:_____

Phone #_____E-mail: _____

❷ 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:

	Diseases	Allergies
_____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
Estimated time of pick up:

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