

**APPLICATION / REGISTRATION FORM**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT'S NAME (LEGAL GUARDIAN) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

EMERGENCY PHONE # \_\_\_\_\_ CONTACT'S NAME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ POLICY # \_\_\_\_\_

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**HEALTH INFORMATION (CIRCLE THOSE APPROPRIATE)**

- |                  |                           |                       |
|------------------|---------------------------|-----------------------|
| Down Syndrome    | Atlanto-axial Instability | Diabetes              |
| Heart Problems   | Seizure Disorder          | Visually impaired     |
| Hearing impaired | Fainting spells           | Non-verbal, signs     |
| Hepatitis        | Bleeding Problems         | Mobility impairment   |
| Asthma           | Emotional Problems        | Learning disabilities |
| Allergies        | High Blood Pressure       | Low Blood Pressure    |
- OTHERS: please list \_\_\_\_\_

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**LIST AIDS USED (such as a wheelchair, hearing aid, glasses etc.)**

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**LIST ALLERGIES**

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**MEDICATIONS:**

NAME	DOSEAGE	TIME GIVEN	SIDE EFFECTS
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**IMMUNIZATIONS:**

	DATE OF LAST SHOT
TETANUS	_____
POLIO	_____
HEPATITIS B	_____

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**LIST ANY OTHER INFORMATION THAT THE COACHING STAFF NEEDS TO KNOW ABOUT YOUR CHILD.**

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