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**CHILD PARTICIPANT'S PERSONAL AND MEDICAL INFORMATION**  
To be completed by parent or guardian: **PLEASE PRINT and use dark ink.**

PARTICIPANT'S NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SCHOOL \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX (IF AVAILABLE): (\_\_\_\_\_) \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ PARENT'S NAME: \_\_\_\_\_

PARENT'S WORK NO.: (\_\_\_\_\_) \_\_\_\_\_ PARENT'S WORK NO.: (\_\_\_\_\_) \_\_\_\_\_

PARENT'S FAX: (\_\_\_\_\_) \_\_\_\_\_ PARENT'S FAX: (\_\_\_\_\_) \_\_\_\_\_

PARENT'S CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ PARENT'S CELL PHONE:(\_\_\_\_\_) \_\_\_\_\_

**PLEASE INCLUDE INFORMATION FOR ALL PARENTS OR GUARDIANS**

E-MAIL ADDRESS \_\_\_\_\_

IN AN EMERGENCY, NOTIFY: \_\_\_\_\_ RELATION TO CHILD: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ ALTERNATE PHONE: (\_\_\_\_\_) \_\_\_\_\_ WK/FAX/PGR

PARTICIPANT'S PHYSICIAN: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

DATE OF MOST RECENT TETANUS TOXOID VACCINATION: \_\_\_\_\_

YOUR HEALTH INSURANCE COMPANY: \_\_\_\_\_ PLAN NO./I.D. NO. \_\_\_\_\_

Non-swimmer?	Yes	No
Any medical conditions which will restrict participation in vigorous physical activity, such as a five mile hike?	Yes	No
Other conditions?	Yes	No
Allergies to plants or medications?	Yes	No
Carries Epinephrine for emergencies?	Yes	No
Taking any regular medication? (Fill out attached medical information form)	Yes	No
Recent surgery, dietary restrictions, or other pertinent medical information?	Yes	No

Please provide details of any items to which you have answered "yes" to above:

\_\_\_\_\_  
\_\_\_\_\_

**Please understand the importance of honest and accurate disclosure. Incomplete or misrepresented information may impact your child's well being.**