



****This form is due Saturday, February 22nd at registration****

PLEASE PRINT or TYPE.

_____ Name	_____ Date of Birth
_____ Address	_____ Phone (Area Code)
_____ Family Physician	_____ Phone (Area Code)
_____ Person to Contact in Case of Emergency	_____ Phone (Area Code)
_____ Insurance Company & Policy Holder	_____ Policy Number

IMPORTANT: Please fill out as completely as possible.

Medications: _____	Dosage: _____
_____	_____
_____	_____

Allergies/allergic reactions to medications: _____

Major surgery in past year: _____

Are you presently under treatment for any medical problem? If yes, please identify: _____

Physical conditions that may limit ensemble activities: _____

Can take (circle): Aspirin Tylenol Motion sickness medication

Date of last Tetanus shot: _____

Special dietary needs: _____

(This information is confidential and will only be used in case of an emergency)