MEMBER'S HEALTH FORM

Name _____

Birth date _____

Parent's Names _____

1. Does your child have any physical complaints or chronic illness at this time? _____

   If so, what? _____

2. Is your child under the care of a physician or practitioner of any sort? _____

   If so, why? _____

3. Is your child taking medicines of any type? No ____Yes _____
   If Yes, Please list:

Medications*:

Name	Dosage

*attach a separate sheet, if necessary.

Is your child on a special diet? _____

If so, what kind? _____

4. Does your child have/ever had:
   a. Diabetes? ____ If yes, are you taking insulin? _____
      How much? _____ What kind? _____
   b. Asthma? _____
   c. Allergy? _____
   d. Any other disorder? _____

5. Physician's Name _____

   Phone _____

6. Insurance Company Name _____

   Policy Number _____

If I cannot be reached, in the event of an emergency, please contact:

Name _____ Phone _____

Name _____ Phone _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the event coordinator to hospitalize and secure proper treatment (including surgery) for my child.

I have read, understand and agree to the above listed statement and do sign this agreement of my own free will.

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

ADDRESS CITY AND COUNTY ZIP

Home Phone _____ Cell Phone _____

Work Phone _____

This form must be reviewed, dated and initialed within 30 days of each trip you plan to attend:

Oct _____ Nov _____ Dec _____ Jan _____ Feb_____ Mar _____

Apr _____ May _____ Jun _____ Jul _____ Aug _____ Sep _____