	MEDICAL & EMERGENCY INFORMATION		
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This form must be completed and signed by you or your Guardian (if you are a minor) and turned in prior to the start of your course.

Name:	Birth date:	Sex:

Contact info participant (or guardian if a minor)

Street:	City:	State :

Zip:	Phone 1:	Phone 2 :

Do you have any special needs? Yes ☐ No ☐
If yes, what are your needs and how can we accommodate them?

Please check those that apply and provide necessary information.

Chronic Ailments:		**Allergies:**	**Specify**
Asthma, or other respiratory problems	☐	Insect bites Bee stings ☐	
Circulatory or heart problems	☐	Foods ☐	
Diabetes or hypoglycemia	☐	Drugs ☐	
Epilepsy	☐	Latex ☐	
Hemophilia, or other bleeding problems	☐	Others, if significant ☐	

Physician who conducted most recent medical exam:

Name:	Phone:	Date:

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Education Law and/or Public Health Law of the State of and on the staff of any hospital holding a current operating certificate issued by the Department of Health It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/hers best judgment may deem advisable. It is understood that effort shall be made to contact the above people prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

In case of an emergency contact:

Name:	Phone:

Signature:	Date:

Participant (or guardian if a minor)