RAQ REGISTRATION AND MEDICAL HISTORY FORM

Athlete's Name: _____ DOB: _____

Age:_____ Weight (lbs) _____

Parents(s) or Legal Guardian (s) Primary Contact Number:

_____ _____

_____ _____

Alt. Contact #'s: (_____) _____ (_____) _____

Email _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone:_____
(Name/Relationship)

Health History: (check giving approximate dates)

____ Measles	____ Poliomyelitis	____ Surgery (major)
____ German Measles	____ Diabetes	____ Accidents (major)
____ Chicken Pox	____ Heart Disease	____ Orthopedic Defects
____ Whooping Cough	____ Rheumatic Fever	____ Menstrual Disorder
____ Tuberculosis	____ Head Injury	____ Seizure Disorder
____ Learning Disability	____ Mental Disorder	____ Other

Subject To: (check)

____ Convulsions	____ Bronchitis	____ Stomach Upsets
____ Sore Throats	____ Fainting	____ Sleep Walking
____ Ear Infections	____ Asthma	____ Bed Wetting
____ Headaches	____ Colds	____ Nightmares

____ Allergies (Medications: Which?) _____

____ Allergies (Food: Which?) _____

____ Allergies (Animals: Which?) _____

Special Medical Attention or treatment or other pertinent information of said minor child not previously mentioned:

_____
_____
_____
_____

Athlete: _____

Insurance Carrier:

_____

(Name) (Address) (Phone)

Insurance Card Number:

_____

Doctor:

_____

(Name) (Address) (Phone)

Dentist:

_____

(Name) (Address) (Phone)

Dental Insurance Carrier:

_____

(Name) (Address) (Phone)

Dental Insurance Card Number:

_____

Please attach a copy of the front and back of the medical card