



# Medical Form



Participant's Name \_\_\_\_\_ DOB \_\_\_\_\_

Parents/Guardians Names \_\_\_\_\_

Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact Person:  
Name \_\_\_\_\_ Phone \_\_\_\_\_

Please List all allergies \_\_\_\_\_

Other Medical Concerns \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Card Number \_\_\_\_\_

Medical Emergency Treatment Authorization

In the event of an emergency and I cannot be reached, the staff of GCYT has permission to seek medical attention for my child

Your Signature \_\_\_\_\_ Date \_\_\_\_\_