Blessed Center Participant Health Declarations

Activity _____Date _____

Participant's Name: _____ DOB: _____
First Last

Address_____
Number and Street City State Zip

Cell Phone (_____) -_____-_____ E-mail _____

Pertinent Medical Information

Check if the participant is allergic to any of the following:

_____bee stings _____poison ivy ____insect bites ____foods

other (if any) – please explain:

_____

Is the participant currently on any medication? _____(please list if yes)

Is there any other information you would like to let the program instructor knows?

_____

Date of last Tetanus shot _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

Date: ___/___/_____Participant Signature:_____

Signature of parent or guardian, if the participant is under 18 years of age

Date: ___/___/_____ Name: _____

Relation with participant: _____ Signature:_____