

Date: _____

YOUTH PARTICIPANT REGISTRATION

Youth Participant Name: _____

Gender: _____ Date of Birth: _____

Grade going into next school year: _____

Age: _____

Height: _____

Cell Phone Number: _____

Email Address: _____

Address: _____

Any Existing Medical Problems: _____

Have you ever had a concussion? _____

If yes, on what date were you cleared by a medical professional to re-engage in athletic activities:

Emergency Contact Name: _____

Emergency Contact Phone number: _____

Emergency Contact Relationship to applicant/participant: _____

Insurance Information

Are you or your dependents entitled to benefits under any Employer Union, Group, Group Blue Cross, Blue Shield, Medicare, Medicaid, or any other governmental program?

Insurance Company Name & Phone number: _____

Subscriber Name: _____

Subscriber's relationship to participant: _____

Subscriber's DOB: _____

Insurance Company Address: _____

Policy #: _____

Group #: _____