

(Please Print Clearly)

Participant's Name _____ Gender _____

Street Address _____ City _____

State _____ Zip Code _____ Phone _____ Birthday ___/___/___

Name of Parent(s)/Legal Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Health Insurance Policy Number _____

Health Insurance Carrier _____

Church/City/State _____

Are you presently taking any prescription or non-prescription medicine on a regular basis? If so, please list.

Are you allergic to any medication or food? If so, please list allergies.

If you are in need of an accommodation, please contact Statewide by _____.

This form must be completed on the FRONT and BACK by ALL participants. NO EXCEPTIONS! Statewide cannot allow anyone to attend without this form.