WWW.PLAYLAX.ORG

Please PRINT in BLUE or BLACK ink:

Applicant's Name (Last) (First) (Middle)

School Currently Attending

Date of Birth/Current Age

Email Address(es)

Parents' Names

Daytime Phone /Cell Phone

Home Address

Applicant's Graduation Year

ALL EMERGENCY MEDICAL INFORMATION REQUIRED

Physician's Name

Physician's Telephone

Hospital Preference

Insurance Company Policy Number

Please check here if you have no medical insurance. _____

Please list any special medication conditions of which the school should be aware. (Include treatment for ADD, ADHD, or other.)

Local Emergency Contact Home Phone Cell or Work Phone
(Other Than Parent)

The following waiver must be signed by parent/guardian of all registrants in order to participate in any program or course.

WAIVER

In the event that my child needs medical attention, I authorize the school and give my consent to the school to provide such service and/or to transport my child to a hospital or treatment facility. I hereby certify that my child is in good health and may participate in all activities. I hereby give permission for my child's picture to appear in future publications.

Parent/Guardian Signature

Date