



## Health Masters Club Mission Statement

**To promote the well-being of children and their families by advocating a healthy lifestyle through education, training, and community outreach.**

### REGISTRATION FORM

School \_\_\_\_\_ Date \_\_\_\_\_ Grade \_\_\_\_\_

STUDENT	First Name	M. I.	Last Name	
	Sex Male _____ Female _____	Age	Date of birth	Phone Number
	Street Address		City	State      Zip
Parent Email:	Mother		Father	
	Phone Number		Phone Number	
Emergency Contact(s)	Name/Phone #		Name/Phone #	
Ethnicity	<input type="checkbox"/> African American <input type="checkbox"/> Other _____	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Multi-Racial	

Is your child eligible for free or reduced lunch?      \_\_\_\_\_ yes      \_\_\_\_\_ no  
 Is your child enrolled in ESOL classes?              \_\_\_\_\_ yes      \_\_\_\_\_ no  
 Is your child enrolled in ESE classes?                \_\_\_\_\_ yes      \_\_\_\_\_ no

## MEDICAL RELEASE AND HISTORY

Health Statement is to be completed by the Parent/Guardian and/or Medical Provider. YES responses will require further explanation.

- |   | YES   | NO    |
|---|-------|-------|
| • Respiratory problems –Asthma, chronic cough, tuberculosis | _____ | _____ |
| • Heart problems - high blood pressure                      | _____ | _____ |
| • Kidney, Stomach, Gall Bladder or Liver problems           | _____ | _____ |
| • Diabetes  | _____ | _____ |
| • Eye, ear nose or throat problems, skin problems           | _____ | _____ |
| • Allergies-Bee stings,plants, food, medications            | _____ | _____ |
| • Seizures  | _____ | _____ |
| • Emotional disorders                                       | _____ | _____ |
| • Physically limiting conditions                            | _____ | _____ |
| • Will your child need medications to be administered?      | _____ | _____ |

I give permission for medications to be given according to the following instructions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Emergency Medical Treatment: I understand that every effort will be made to contact the parent or guardian of participants. If this is not possible, I hereby authorize the Health Masters Club to obtain medical treatment.

Parent/Guardian signature \_\_\_\_\_ Phone# \_\_\_\_\_  
 Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Waiver: I hereby state that my child is physically and mentally capable of safe participation in the Health Masters Camp activities. I understand and expressly acknowledge that I release the program and its staff from all liability for any injury, loss or damage connected in any way to my child’s participation. I give permission to the Health Masters Camp program to use, without limitation or obligation, photographs, film footage, or tape recording which may include my child’s image or voice. I hereby give my permission for my child to be transported to and from any scheduled field trips.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

