

# AEYF Conferences

Conference: \_\_\_\_\_

Date of conference: \_\_\_\_\_ Through \_\_\_\_\_

## Registration and Medical Release Form

Name \_\_\_\_\_

Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Name and Phone of emergency contact if parents cannot be reached.

Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

For this period stated above, we, the undersigned authorize the AEYF Executive Committee or their designated alternate(s) to obtain emergency medical treatment including but not limited to hospitalization, injections, anesthesia or surgery, for the individual listed above.

Important medical information (medicines being taken, allergic reactions to any medication, important medical history.):

Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_

Signature of Participant \_\_\_\_\_

Signature of Parent (if participant is under 18) \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_