

2017 PASDA Registration/Medical Form  
Hamilton Township Recreation Department  
**DUE May 25, 2017**

**Registering for:** (circle one) PASDA

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
First Middle initial Last (as of 6/1/17)

ADDRESS: \_\_\_\_\_  
Street Town State Zip Code

HOME PHONE: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Parents names and cell phone #'s:

Guardian \_\_\_\_\_ Guardian \_\_\_\_\_

**T-SHIRT SIZE Youth: S M L Adult: S M L XL CIRCLE ONE**

**MEDICAL INFORMATION:**

Emergency contact : \_\_\_\_\_  
Name Phone # relationship

Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_ Hospital: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ ID # \_\_\_\_\_ last 4 digits SSN \_\_\_\_\_

Are you allergic to any medications? No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you take any prescribed medications on a permanent or semi-permanent basis?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you have asthma or other respiratory disease? No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Do you have any learning disabilities that the coaching staff should be aware of?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Are there any other issues that the coaching staff should be aware of?  
No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Participation in HAC programs requires an annual physical. Date of last physical: \_\_\_\_\_

If a medical emergency or illness occurs, I authorize the coaching staff of Hamilton Aquatics to send my child to a physician or hospital, and authorize emergency medical treatment.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT RESPONSIBILITIES**

Should my child be responsible for damage to the facilities/equipment at their practice location I understand that I am responsible for restitution.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_