

Vaulter Name _____ Birthdate _____

Please list names and numbers for three contacts in case of an emergency.

1. Emergency Contact _____
Home Address _____
Home Phone _____ Work Phone _____
Cell Phone _____ Other _____

2. Emergency Contact _____
Home Address _____
Home Phone _____ Work Phone _____
Cell Phone _____ Other _____

3. Emergency Contact _____
Home Address _____
Home Phone _____ Work Phone _____
Cell Phone _____ Other _____

Name of Insurance Company _____
Name of Policy Holder _____
Group # _____ Policy # _____ Insurance phone number _____

Physician's Name _____ Phone _____
Dentist's Name _____ Phone _____
Hospital of Choice _____ (EMT or Paramedic may override choice)

Does the vaulter have health conditions that may affect vaulting? (Heart condition, Diabetes, Asthma, Allergies, Seizure Disorder, etc.) Describe: _____

Medications/Other _____

Date of vaulter's last tetanus shot _____

Does vaulter uses an asthma inhaler? Yes No **Please bring to all vaulting practices and events.**

I give my permission for NEV to administer Acetaminophen/Ibuprofen, an antihistamine, or first aid to my child, if needed. Yes No

I give permission to exchange information with my (vaulter's) physician. Yes No

Please sign and date,

Vaulter _____ Date _____

Parent 1 /Guardian _____ Date _____

Parent 2 /Guardian _____ Date _____