ANTHRACITE COMBAT CLUB SUMMER CAMP REGISTRATION FORM

STUDENT INFORMATION Middle: Middle: Middle: Middle: Mi	Today's date:												
Birth date: Age: General	STUDENT INFORMATION												
	Last name:				First:	First:		Middle:					
Street address: City: State: Zip Code: Email: Mother's Name: IN CASE OF EMERGENCY Name (please list 2) Relationship to student: Home phone no.: Cell phone # for text messages.: State: IN CASE OF EMERGENCY Name (please list 2) Relationship to student: Home phone no.: Cell phone no.: Cell phone no.: Cell phone no.: Cell phone no.: Father's Name: Father's Name: Father's Phone: Insurance Company: Policy #: Group#:	Birth date:	Age:	Gen	der:	•								
City: State: Zip Code: Email: Mother's Name: Father's Name: Father's Name: State: Stat	/ /		□м	л 🗀 ғ									
Zip Code: Email: Mother's Name: Mother's Phone: () Father's Phone: () IN CASE OF EMERGENCY Name (please list 2) Relationship to student: ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	Street address:												
Email: Mother's Name: Father's Phone: () Father's Phone: () IN CASE OF EMERGENCY Name (please list 2) Relationship to student: ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	City:		State:					•					
Mother's Name: Father's Name: Father's Name:	Zip Code:									_			
Mother's Phone: () IN CASE OF EMERGENCY Name (please list 2) Relationship to student: Home phone no.: Cell phone no.: ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	Email:												
IN CASE OF EMERGENCY Name (please list 2) Relationship to student: Home phone no.: Cell phone no.: ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	Mother's Name:		Father's Name:										
Name (please list 2) Relationship to student: Home phone no.: Cell phone no.: ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	Mother's Phone: (Father's Phone: ()										
ADDITIONAL INFORMATION Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	IN CASE OF EMERGENCY												
Physician Contact Information: Name: Phone: Insurance Company: Policy #: Group#:	Name (please list 2)					Relationship to student	Home phone no.		no.:	Cell phone no.:			
Name: Phone: Insurance Company: Policy #: Group#:	ADDITIONAL INFORMATION												
Phone: Insurance Company: Policy #: Group#:	Physician Contact Information:												
Insurance Company: Policy #: Group#:	Name:												
	Phone:												
Hospital Preference:	Insurance Co	mpany:				Policy #:		Group#:					

Does the student have any allergies and/or intolerances to food, medication or any other substances? What are the symptoms and action to be taken if any?

Please provide information on any medication being taken, chronic physical problems, pertinent developmental information, and any special accommodations needed. Attach additional sheets if necessary.