

Date:	Last Name:	Age:
Swimmer: YES NO	Pool:	
L.M.T.: YES NO	Time:	
GO2: YES NO		
Volunteer: YES NO		

Great Opportunities  
30986 Calle San Diego, San Juan Capistrano, CA 92675  
Email: info@greatopps.org

**GREAT OPPORTUNITIES  
PARTICIPATE REGISTRATION AND MEDICAL INFORMATION FORM**

\*\*\*Please print clearly\*\*\*

Participants Name: (First, M.I., Last)	Birthdate:	Age:
Address:		
Home Phone #:	Gender: Male: _____ Female: _____	
Email:	Grade in:	

**PHYSICIAN OR CLINIC (Please print clearly)**

Physician's Name:	Facility Name:
Office Phone #:	

**HEALTH INSURANCE INFORMATION**

Carrier Company:	Policy/Medical #:
Office Phone #:	Fax Number:

**\*\*Please attach a photocopy of Medical card and/or sticker\*\***

<p align="center"><b><u>HEALTH HISTORY</u></b></p> <p>(Please list any health restrictions we need to know about)</p> <p>Comments/Restrictions:</p> <hr/> <hr/> <hr/> <hr/> <hr/>	<p align="center"><b><u>LIST ALL ALLERGIES:</u></b></p> <p>Food: _____</p> <p>Medicine: _____</p> <p>Other: _____</p> <p align="center"><b><u>LIST ALL MEDICATIONS BEING TAKEN AT THIS TIME</u></b></p> <table border="1" style="width: 100%;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>								

**EMERGENCY CONTACTS**

Parent/Guardian Name:	Name/Relationship:
Address:	Address:
Home Phone #:	Home Phone #:
Cellular Phone #:	Cellular Phone #:
Email (Additional):	Email:

---

Signature of Parent and/or Guardian

---

Date