

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

Participants Name: (First, M.I., Last): \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**PHYSICIAN OR CLINIC (Please print clearly) HEALTH INSURANCE INFORMATION**

Physician's Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Physician's Office Phone #: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Policy/Medical #: \_\_\_\_\_ Insurance Office Phone #: \_\_\_\_\_

**HEALTH HISTORY**

(Please list any health restrictions we need to know about) Comments/Restrictions:

LIST ALL MEDICATIONS BEING TAKEN AT THIS TIME and LIST ALL ALLERGIES:

Allergies: \_\_\_\_\_

Medicine: \_\_\_\_\_

Other: \_\_\_\_\_

**EMERGENCY CONTACTS**

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Signature of Parent and/or Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

**Pool:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Swim Level:** \_\_\_\_\_

**Will they join the beach program?: Yes or No**

*\*Children will be dropped off at the corner of Calle San Diego between the hours of 4:30pm and 5:30 pm if attending the beach program.\**

**Dropoff/Pickup location: 30986 Calle San Diego, San Juan Capistrano, CA 92675 Email: [info@greatopps.org](mailto:info@greatopps.org)**