AEYF Conferences

Conference: _____

Date of conference: _____

Registration and Medical Release Form

Name _____

Birth Date _____/_____/_____ (MM/DD/YYYY)

Address _____

City _____ State _____ Zip/Postal Code _____

Cell Phone (_____) _____ - _____ E-Mail Address _____

Father's Name _____ Phone (_____) _____ - _____

Mother's Name _____ Phone (_____) _____ - _____

Name and Phone of emergency contact if parents cannot be reached.

Name _____ Phone (_____) _____ - _____

Family Doctor _____ Phone (_____) _____ - _____

For this period stated above, we, the understigned authorize Rev. Ara Jizmejian or his designated alternate to obtain emergency medical treatment for the individual listed above, including hospitalization, injections, anesthesia or surgery.

Important medical information (medicines being taken, allergic reactions to any medication, important medical history.):

Insurance Carrier_____

Policy #_____

Signature of Participant _____

Signature of Parent (if participant is under 18) _____

Date_____ / _____ / _____