

**Red Wing Family YMCA School Year  
Registration Form**

THE FOLLOWING INFORMATION MUST BE COMPLETED.

The intent of the completed information in this Health Form is to provide the director/ and staff the background to administer appropriate care to the participant named below while he or she is attending our School Year – School Age program. Any changes to this form should be provided to Child Development Center Director.

**Personal Information**

Name of Participant: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Gender (Male/Female): \_\_\_\_\_

Participant Permanent Address: \_\_\_\_\_

Parent's/Guardian's Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Relation: \_\_\_\_\_

Parent's/Guardian's Home Address (if different from above): \_\_\_\_\_

Parent's /Guardian's Business Name and Phone: \_\_\_\_\_

2<sup>nd</sup> Custodial Parent/Guardian (if applicable): \_\_\_\_\_ Relation: \_\_\_\_\_

2<sup>nd</sup> Parent's/Guardian's Address (if different from above): \_\_\_\_\_

2<sup>nd</sup> Parent's/Guardian's Phone (if different from above): \_\_\_\_\_

2<sup>nd</sup> Parent's/Guardian's Business Name and Phone: \_\_\_\_\_

*In an emergency, if no parent or guardian is available, please contact:*

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Insurance Information**

Is the participant covered by family medical/hospital insurance? (Yes/No): \_\_\_\_\_

If so, indicate carrier or plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Insurance ID # of Policy Holder: \_\_\_\_\_

**Medical Provider Information**

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name of Family Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Dietary Restrictions**

List any specific dietary limitations (e.g., does not eat red meat, pork, seafood, poultry, eggs, dairy products, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

List all known.

Type of allergy	Possible reaction	Care for reaction

**Immunizations will need to be provided. If you are currently enrolled with no new shots and we have them on file , no action is needed.**