BRAWLEY FARMS
MEDICAL INFORMATION

Name: _____
Date of Birth: _____Sex: M () F () Height: _____ Weight:_____
Parent Name (If Minor): _____
Address: _____
Phones - Home: _____ Work: _____ Cell:_____
Emergency Contact: _____ Phone: _____
Address: _____ Relationship: _____
Physician: _____ Phone: _____

EMERGENCY INFORMATION

Has had head injuries requiring medical treatment?	YES () NO ()
Has had illness lasting more than one week?	YES () NO ()
Is under a doctor's care now?	YES () NO ()
Takes medication now?	YES () NO ()
Wear glasses?	YES () NO ()
Wear Contact lenses?	YES () NO ()
Has had surgical operation (except tonsillectomy)?	YES () NO ()
Has been in a hospital?	YES () NO ()
Is there any reason this child should not participate in strenuous physical activity?	YES () NO ()
Allergic to any medications?	YES () NO ()

EXPLAIN ANY "YES" ANSWERS: _____

_____

_____

While I expect BRAWLEY FARMS, their employees or agents to exercise reasonable precautions to avoid injury. I understand that they assume financial obligation or other liability for any injury that may occur.

SIGNATURE: _____ DATE: _____

In case of emergency, I hereby authorize BRAWLEY FARMS, their employees agents to take if my child or myself to the most available physician or send either by emergency carrier to the nearest hospital emergency room.

SIGNATURE: _____ DATE: _____

In case of emergency, BRAWLEY FARMS, their employees or agents are given full authority to perform necessary first aid and seek any necessary medical treatment for my child or myself.

SIGNATURE: _____ DATE: _____