Solanco Cheerleading Association

P O BOX 343

Quarryville PA 17566

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www.solancomules.com

HEALTH RECORD FORM

PLEASE PRINT:

Child's Name:_____DOB: _____Age: _____

Parent(s)/Guardian Name:_____
Address:_____
Cell Phone: _____Texting: Yes or No_____

EMERGENCY CONTACT OTHER THAN PARENT:

Name:_____

Address:_____
Cell Phone: _____Texting: Yes or No_____

MEDICAL INFORMATION:

Physician's Name:_____ Phone: _____

Existing medical conditions coach should be aware of: _____
_____
_____

Allergies:_____
Medicine that needs to be taken:_____ Number of Times: _____

Preferred Hospital:_____

To the best of my knowledge, the above information is correct and I hereby give my permission for Solanco Cheerleading Association coaching staff to administer medicine that my child will require during the cheerleading season.

PARENT/LEGAL GUARDIAN _____Date_____