True Athlete Camps & Clinics
Registration Form

PARTICIPANT INFORMATION

Participant Name:_____ Participant Date of Birth:_____

Participant Grade (2023-2024 school year): _____ Years of experience: _____

Parent/Guardian Name: _____ Primary Phone Number:_____

Address: _____ Email: _____

EMERGENCY CONTACTS

Emergency Contact Name: _____ Phone Number: _____

Relationship to participant: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to participant: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to participant: _____

MEDICAL INFORMATION

Does the participant have any allergies? ☐ YES ☐ NO

If so, please list: _____

Does the participant have asthma? ☐ YES ☐ NO Use an inhaler? ☐ YES ☐ NO

If so, are there any special instructions you'd like us to know about? _____

Does the participant have any other medical conditions we should know about? ☐ YES ☐ NO

Please list: _____

_____

Primary Care Physician: _____ Phone: _____

Health Insurance Carrier: _____ Member ID: _____

Group Number: _____ Primary Subscriber Name: _____

Preferred Hospital: _____

How did you hear about us? ☐ Friend/Family ☐ Online Search ☐ Social Media ☐ Local Advertising ☐ Email Marketing ☐ Digital Advertising