**Emergency Contact and Health Form**

WARRIOR SCHOOL DATES: June 17-21, 2019; June 24-28, 2019 (circle one)

This form must be completely filled out and returned to Courtney LeDuc, Youth Director, at least 30 days prior to the start of your session. Thank you.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age: \_\_\_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Mother/Guardian #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

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

Work Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

Father/Guardian #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

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

Work Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

If neither of the above is available in an emergency, please notify:

Alternate Contact # 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Contact #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have Insurance? Y N If Yes, Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_ Policy or Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent’s Authorization**: This form is correct so far as I know, and the person herein described has permission to engage in all Warrior School activities. I understand there is some inherent risk in activities at Warrior School and accidents sometimes occur. I understand that the school fee does not include accident insurance. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give my permission to the physician selected by the youth director to order x-rays, routine tests and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the youth director to hospitalize, secure proper treatment for, and to order interventions for my child as named above. I agree that after a place is reserved my child will remain until the end of the period unless necessary to withdraw due to illness. I understand that no refunds are given if a child leaves early for disruptive behavior as decided by the youth director.

I understand that if my child has special health issues I must call the director at (303)396-5104, at least 30 days in advance, to determine if the Warrior School can provide the level of care and special attention needed by my child. I understand that The Althea Center for Engaged Spirituality is not a healthcare facility and may not be able to reasonably care for my child’s special needs. Health conditions requiring advance clearance include but may not be limited to: *Insulin Dependent Diabetes, Cardiac Situations, Asthma and Allergies, Seizure Disorders, Autism, and Serious Food Allergies*.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_