



**REGISTRATION AND MEDICAL RELEASE FORM 2009**

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Your Center: \_\_\_\_\_

***Please note:***

- (1) Keep notarized form in your vehicle **at all times!!**
- (2) Attach a copy of your medical insurance card to this form.
- (3) Give a copy of this form to the Center Staff upon your arrival.

**REGISTRATION INFORMATION:**

Participated with ASP before? (circle) Yes No

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Nickname \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Marital Status (circle 1) single married  
widowed divorced

Birthday \_\_\_\_\_ (mon/day/year)

Gender (circle) Male Female

Occupation \_\_\_\_\_

Email address \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION:**

Medical information on this form will **only** be used if medical treatment is needed. It will be used for no other purpose.

Social Security # \_\_\_\_\_ (optional) Date of last Tetanus shot \_\_\_\_\_

Medication(s) you are currently take (prescribed & over-the-counter – please list all – this is **extremely** important!!)

\_\_\_\_\_

\_\_\_\_\_

Medication(s) you **CANNOT** take \_\_\_\_\_

Any allergies &/or special health problems or concerns \_\_\_\_\_

\_\_\_\_\_

**Medical insurance information:**

Company name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Policy # \_\_\_\_\_

Policy Holder's ID # \_\_\_\_\_

Relationship to policyholder \_\_\_\_\_

**In an emergency, please contact:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Day Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Also on ASP? (circle) Yes No

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Day Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Also on ASP? (circle) Yes No

**Physician information:**

Physician name \_\_\_\_\_ Phone \_\_\_\_\_