TITO GAONA'S FLYING FANTASY CIRCUS, Inc.

REGISTRATION AND MEDICAL FORM FOR ADULTS (AGES 18 AND OVER)

Please fill out this form completely and sign it.

PLEASE PRINT LEGIBLY

Participant's Name: ______________________________ Date of Birth: _____(mo.)/_____(day)/________(yr.)

Participant's Address: ______________________________

Participant's City/Town: ______________________________State/Zip:__________________

E-Mail Address: ______________________________

Home Phone: (________)____________ Work Phone: (________)____________ Cell Phone: (________)____________

Emergency Contact:______________________________ Phone: (________) ____________________

Physician: ______________________________ Phone: (________) ____________________

Do you have any physical problems, restrictions, limitations or conditions that might limit your activity on the trapeze?
(rotator cuff tear, limited grip strength, sports-related injuries, back or shoulder injuries etc.)

____

Have you experienced pain or difficulty with movement in any of the following areas? (check any/all that apply)

______Neck ______Wrist ______Lower Back ______Shoulders ______Arms ______Hips _____ Elbows _____Hands ______Knees

Other important medical information:______________________________

____

____

____

Participant's Signature **Date**

Registration fee is $40.00 per participant:

Flying Fantasy Circus, Inc.

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