

TITO GAONA'S FLYING FANTASY CIRCUS, Inc.



REGISTRATION AND MEDICAL FORM FOR MINOR CHILDREN (UP TO AGE 17)

A parent or legal guardian must fill out this form completely and sign it for each minor child participant..

PLEASE PRINT LEGIBLY

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

Participant's Address: _____

Participant's City/Town: _____ State/Zip: _____

Mother's Name: _____ Father's Name: _____

Guardian's Name: _____

E-Mail Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Physician: _____ Phone: (____) _____

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

Has the participant 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

Medical History:

____ Allergies ____ Hay fever ____ Asthma ____ Drugs ____ Insects ____ Food Allergies ____ Fainting

____ Bloody nose ____ Recurring Illness ____ Headaches ____ Heart disease ____ Convulsions

Please be more specific as to any medical concerns _____

As the parent or legal guardian, I give permission for my minor child to participate fully in the program offered, including flying on the trapeze and using the trampoline.

It is my understanding that every effort will be made to contact the parent or legal guardian prior to medical treatment. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Tito Gaona and/or his staff to hospitalize or secure treatment for my child as named above.

Parent/Guardian Signature

Date

Registration is \$40.00 per class, or \$250.00 a week for the summer program

Flying Fantasy Circus, Inc.

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