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**

Flying Fantasy Circus, Inc.

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