

Wall Crawler Rock Club

Health Information

Please complete each page in its entirety. These forms must be completed before the start of the program.

Program _____ Program Date _____

Full name of participant _____ Preferred name _____

Mailing address _____ City _____ St _____ Zip _____

Home phone _____ Gender _____ Age _____ Birth date _____

Parent/guardian name _____

Address _____ City _____ St _____ Zip _____

Home phone _____ Cell phone _____

Employer _____ Work phone _____

Email _____

Emergency Contact _____ Phone _____ Relationship _____

Parent/guardian name _____

Address _____ City _____ St _____ Zip _____

Home phone _____ Cell phone _____

Employer _____ Work phone _____

Email _____

Emergency Contact _____ Phone _____ Relationship _____

I authorize the following people to pick up my child from Wall Crawler Rock Club programs:

Name

Relationship

Phone

The following people are prohibited to pick up my child from Wall Crawler Rock Club programs:

Name

Relationship

Wall Crawler Rock Club 1522 Dekalb Ave, Atlanta, GA 30307

404-371-8997 wallcrawlerclimbing@gmail.com

Wall Crawler Rock Club

Medical Information

Please include any pertinent information in the area provided.

Pain or injury: _____ Neck _____ Back _____

_____ Diabetes _____ Seizures _____ Asthma _____

_____ Chronic illness _____

Current medications _____

Allergies: _____

Dietary restrictions _____

Please expand upon any behavioral, social or learning disabilities that would help me better understand your child. _____

Insurance information

Parents and guardians are responsible for any medical expenses and should be covered by their own medical insurance.

Is the participant covered by hospitalization and medical insurance? _____yes _____no

Insurance company _____

Policy number _____

Primary care physician _____

Preferred hospital / ER _____

Please make a copy of your health insurance card and submit with this form.

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