BIG BRO JOE FOUNDATION REGISTRATION PACKET

Address: 6855 W. Clearwater Ave. Ste A101 #146, Kennewick, WA, 99336 | **Website:** bigbrojoe.org

CHILD'S FULL LEGAL NAME (last, first, middle)	BIRTHDAY mm/dd/yyyy	AGE	CITY, STATE OF BIRTH	Shirt Size
Primary Contact for Emergency- Name:			**Number:**	
Child's Primary Information				
Home Address:	**City:**		**State:**	**Zip:**
Parent 1 Name:	**Relationship to Child:**			
Occupation:	**Place of Employment:**			
Cell Phone:	**Work Phone:**	**Email:**		
Parent 2 Name:	**Relationship to Child:**			
Occupation:	**Place of Employment:**			
Cell Phone:	**Work Phone:**	**Email:**		

Child's Pick-up Information

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.
Parent/Guardian signature: ___________________________________ Date: _________________ **In an emergency, if you are not able to contact me, contact the following:**

Name (first, last)	Phone #	Relationship to child

The following individuals have permission to pick up my child:

Name (first, last)	Phone #	Relationship to child

The following individuals DO NOT have permission to pick up my child:

Name (first, last)	Reason	Relationship to child

Child's Health Care Information				
Health Care Providers			**Health Concerns**	
Physician:	**Phone Number:**	**Address:**	**Current Medications:**	
Dentist:	**Phone Number:**	**Address:**	**Health History:**	
Hospital:	**City:**		**Allergies, please list below (please provide a health care plan from doctor):**	
Other (type):	**Name:**	**Phone Number:**		
Child's Medical Insurance Coverage				
Primary insurance company name:			**Member/ policy number:**	
Policy holder's name:			**Employer's name:**	
Consent to medical care and treatment of minor children				

I give permission that my child, ____may be given

first aid/emergency treatment by the founder or qualified mentor within the Big Bro Joe Foundation.

Parent/ Guardian Signature	**Date**	**Parent/ Guardian Signature**	**Date**

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital, or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/ Guardian Signature	**Date**	**Parent/ Guardian Signature**	**Date**

Child’s School Information	
School Name:	**Grade:**
School Number:	**School Address:**