



Shiprock Kids Marathon

GENERAL INFORMATION

*Name _____

*Parent's Name: _____

*Address, town/city, state and zip _____

*Chapter _____ *School: _____ Grade _____

Birthday: ___/___/___ *Age: ___ Height ___ Weight ___

Sports, clubs or hobbies: _____

*Emergency contact: _____

*Relationship to child: _____ Phone: _____

Address: _____

*Parents - Do you have any questions or concerns about your child's ability to meet the physical demands and challenges of the Shiprock Kid's Marathon?

Parental permission, waiver and medical release:

I give permission for my child, _____, to take part in the 2021 Shiprock Kids Marathon. I will not hold Y.E.S. for Dine' Bikeyah (NavajoYES), Shiprock Marathon race committee and volunteers, my child's school, or sponsors responsible or liable for any accidents, injuries or thefts that my child may incur through participation in this program. I authorize representatives of my child's school, NavajoYES and/or Shiprock Marathon to obtain emergency medical treatment if it should become necessary.

Parent/Guardian's Signature

Date



Questions? Contact us at chuskaman@yahoo.com or 505-686-2300

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HEALTH HISTORY

Does your child have any **special medical/health conditions** that we should be aware of?

Any **allergies**? Medications, bees, certain foods, etc? If so, please list.

Does your child take any **medications, vitamins or supplements** on a regular basis? If so, identify. _____

When was your child's most recent **tetanus shot**? (If you can't recall, just say so.) _____

General Health Questions. *Please circle all items with which your child has had issues with in the past.* This is VERY IMPORTANT, so please take your time.

Seizures

Heart Defect/high blood pressure

Diabetes

Joint issues/dislocations

Heat Stroke

Asthma

Sleep walking

Allergic reactions (bee stings, food, medications, etc.)

Head injury/concussion/TBI

Chronic or recurring illness/Recent injury, illness or infectious disease?

Please explain any items circled above:

Please describe any limitations or restrictions on activities:

Please describe any medically-prescribed meal plans or dietary restrictions. If you have not done so above, **please note any food allergies.**

At which local clinic or hospital does your child normally receive services?
