Monument Valley Kids Marathon

GENERAL INFORMATION

Name _____

Parent's Name: _____

Address, town/city, state and zip _____

_____

Chapter _____ School: _____ Grade (in fall) _____

Birthday: ____/____/____ Age: _____ Height _____ Weight _____

Sports, clubs or activities at school: _____

Special interests, hobbies or skills: _____

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 Monument Valley Kids Marathon?

_____

Parental permission, waiver and medical release: I give permission for my child, _____, to take part in the 2016 Monument Valley Kid's Marathon. I will not hold Y.E.S. for Dine' Bikeyah (NavajoYES), Monument Valley race committee and volunteers, Monument Valley Navajo Tribal Park, Navajo Parks & Recreation, Office of Navajo President & Vice President 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 Monument Valley Marathon to obtain emergency medical treatment if it should become necessary.

_____ _____
Parent/Guardian's Signature Date

Monument Valley Kids Marathon

HEALTH HISTORY

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

_____

_____

Any allergies to medications, certain foods, etc? If so, please list. _____

_____

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

_____

_____

General Health Questions (Please circle all items to which the answer is "yes")

Has/does your child"

Ever had seizures?	Have a heart defect?
Ever passed out during exercise?	Ever had a head injury?
Ever had back problems?	Have diabetes?
Have asthma?	Have high blood pressure?
Wear glasses or contacts?	Ever been knocked unconscious?
Have a chronic or recurring illness?	Had any recent injury, illness or infectious disease?
Have problems with sleep-walking?	Ever had problems with joints?

Please explain any "Yes" answers to the above items:

_____

_____

_____

Please describe any limitations or restrictions on athletic activities:

_____

_____

Please describe any medically-prescribed meal plans or dietary restrictions:

_____

_____

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