

Monument Valley Kids Marathon



GENERAL INFORMATION

Name _____

Parent's Name: _____

Address, town/city, state and zip _____

Chapter _____ School: _____ Grade _____

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 2018 Monument Valley Kids Marathon at Monument Valley Navajo Tribal Park on Friday, November 16. 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**? 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?
