Shiprock Kids Marathon

GENERAL INFORMATION

Name ____

Parent's Name: ____

Address, town/city, state and zip ____
____

Chapter ______________________ School: _____________________________ Grade _______

Birthday: ____/____/____ Age: _____ SHIRT SIZE: __________________

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 2023 Shiprock Kids Marathon. I understand that the Kids Marathon is a home and school-based event, with the running all taking place at our home or my child's school.

____ ____________________
Parent/Guardian's Signature Date

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

Shiprock 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?