City of La Grange
Membership Registration and
Emergency Medical Information

Participant Name _____ _____ _____
Last First Middle

___/___/_____ ____ _____
Date of Birth Age Gender

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Business/Cell Phone _____

Email _____

Emergency Contact _____ Phone _____

Emergency Contact _____ Phone _____

Doctor of Choice _____ Phone _____

Do you have any Allergies: ___ Yes ___ No If YES, What type (please check all that are applicable):

Type of Allergy	Life Threatening
___ Bee Sting	___
___ Peanut	___
___ Poison Ivy	___
___ Pollen, Trees, Grass, Weeds, etc.	___
___ Other _____	___

Type of Allergy	Life Threatening
___ Drugs _____	___
___ Foods _____	___
___ Other _____	___

Please explain Allergy in detail and what Symptoms occur:

_____

_____

Do you have any reoccurring illness(es)? ___ Yes ___No If YES, What type (please check all that are applicable):

___ Asthma ___ Diabetes Type I ___ Diabetes Type II ___ Seizure Disorder ___ Cardiac ___ Pneumonia
___ Bronchitis ___ Ear Problems ___ Kidney Problems ___ Convulsions ___ Tonsillitis ___ Other

Please explain in detail:

_____

_____

Are you on any medication at the present time: ___ Yes ___ No For what reason? _____

I, (_____), authorize the City of LaGrange, its agents, employees, officers, and servants, all activity leaders, supervisors, and any volunteers donating their services to the City of La Grange to obtain medical treatment for myself should an apparent need for this treatment arise. This document shall constitute consent and authorization for aforementioned parties to consent to any medical treatment at any time should the need arise, but shall impose no duty upon any person to obtain any medical treatment for an person regardless of their condition.

_____ _____
Member/Participant Signature Date