Youth Program Health Information

Name of Participant: __________________________________ Age: _______________

Name of Parent/Guardian: __________________________________

_________ (parent initials) I hereby agree that the following information is true to the best of my knowledge and agree to inform Southeastern Oneida Tribal Services and its' staff of any changes or updates.

1. List any allergies, health concerns, and/or medications (and any adverse side effects if applicable):

2. List any dietary or physical ability restrictions:

3. List at least one secondary emergency contact:
    a. Name
    b. Phone
    c. Relationship to participant

In the event the participant becomes ill or injured, Southeastern Oneida Tribal Services (SEOTS) acting through its employees, agents, chaperones, and volunteers shall make every effort to contact me for arrangement to return my child home and into my care.

Signature of Parent/Guardian: ____ Date: _____________

Full Address: ____

Phone: ______________________________________ Email: _____________________________________