MCCS YOUTH ACTIVITY PROGRAMS
MARINE CORPS BASE HAWAII KANEOHE BAY

Registration Form

Sponsor Name:		Work Phone:		Rank:
Spouse Name:		Work Phone:		Rank:
Home Address:		Sponsor Cell Ph:		
		Spouse Cell Ph:		
Home Phone:		E-mail Address:		
1st Child's Name:		Date of Birth:		☐ Male ☐ Female
		T-Shirt Size:	Youth ☐ Adult ☐	☐S ☐M ☐ Lg ☐ XLg
2nd Child's Name:		Date of Birth:		☐ Male ☐ Female
		T-Shirt Size:	Youth ☐ Adult ☐	☐S ☐M ☐ Lg ☐ XLg
3rd Child's Name:		Date of Birth:		☐ Male ☐ Female
		T-Shirt Size:	Youth ☐ Adult ☐	☐S ☐M ☐ Lg ☐ XLg

4th Child's Name:		Date of Birth:		☐ Male ☐ Female
		T-Shirt Size:	Youth ☐ Adult ☐	☐S ☐M ☐ Lg ☐ XLg

Child Medical Information:

Special Needs: Does your child(ren) have any special needs? If yes, Please describe:

(1st Child): ______________________________

(2nd Child): ______________________________

(3rd Child): ______________________________

(4th Child): ______________________________

Medical Needs: Please list below any medical condition, medications, allergies, etc.

(1st Child): ______________________________

(2nd Child): ______________________________

(3rd Child): ______________________________

(4th Child): ______________________________

Emergency Contacts: (Other than parent/guardian)

These people may be called in an emergency to act on my behalf in the event that I cannot be reached.

Name:		Relationship:	
Home Phone:		Work/Cell Ph:	
Name:		Relationship:	
Home Phone:		Work/Cell Ph:	
Name:		Relationship:	
Home Phone:		Work/Cell Ph:	

In the event that my child exhibits signs of illness or injury, I understand the Youth Activity staff will contact me immediately so that I can obtain medical treatment for my child. In the event that I cannot be immediately contacted, I understand the Youth Activity Staff will contact one of my listed emergency contacts so that they can obtain medical treatment for my child. If contact cannot be made with listed emergency contacts, I appoint the Activity Supervisor and Medical Personnel at the Kaneohe Dispensary, Trippler Army Hospital or Preventive Medicine to obtain medical treatment deemed necessary by Medical Department personnel until I can be reached.

Parent/Guardian Signature:______________________________ Date: ____________