



PROGRAM ENTRY FORM

PARTICIPANT INFORMATION

NAME	
ADDRESS	
CITY	
STATE/ ZIP	
EMAIL ADDRESS	
PHONE NUMBER	
DOB	
AGE	
HIGH SCHOOL	
SPORT(S)	

PARENT/GUARDIAN INFORMATION

NAME	
ADDRESS	
CITY	
STATE	
ZIP	
PHONE NUMBER	

EMERGENCY CONTACT (PRIMARY AND SECONDARY)

NAME/ RELATIONSHIP	
PHONE NUMBER (LIST ALL)	
NAME/RELATIONSHIP	
PHONE NUMBER (LIST ALL)	



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PLEASE FILL OUT THE FOLLOWING INFORMATION AND HAVE THE PARTICIPANT'S PRIMARY CARE PHYSICIAN APPROVE PARTICIPATION. A PARENT/GUARDIAN SIGNATURE IS ALSO REQUIRED.

ANY ACTIVITY RESTRICTIONS? CURRENT? PAST 5 YEARS?

ANY SURGERIES OR HOSPITALIZATIONS?

PHYSICIAN APPROVAL

**I _____ (PHYSICIAN NAME) APPROVE THAT
_____ (CHILD'S NAME) IS IN GOOD HEALTH
AND CAN PARTICIPATE IN BOSTON SPORTS MEDICINE'S STRENGTH
AND CONDITIONING PROGRAM.**

SIGNATURE OF PHYSICIAN:_____

DATE OF PHYSICIAN SIGNATURE:_____

**I HEREBY GIVE THE PARTICIPANT APPROVAL TO PARTICIPATE IN
BOSTON SPORTS MEDICINE'S STRENGTH AND CONDITIONING
PROGRAM.**

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE:_____

DATE OF PARENT/GUARDIAN SIGNATURE:_____