VINCO GROUP, LLC

REGISTRATION FORM

(Please Print)

Today's date:	Course:

STUDENT INFORMATION

Name:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name):	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address: (Optional)	Social Security #: (Optional)	Home/Cell Phone: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation: (Optional)	Employer:(Optional)	Phone: (Optional) ( )

Referred to VINCO Group, LLC by (please check one):

❑ Family ❑ Friend ❑ Work ❑ Internet ❑ Other _____________

MEDICAL INFORMATION

Do you have a pacemaker?
❑ Yes ❑ No

Do you take any medications that require refrigeration?
❑ Yes ❑ No

Are you a diabetic?
❑ Yes ❑ No

Do you have any medical conditions we need to be aware of?
❑ Yes ❑ No

Have you ever had a seizure?
❑ Yes ❑ No
If yes, provide date: ____________________________

Is this participant covered by insurance? ❑ Yes ❑ No Please indicate primary insurance: ___________________________________

Do you have any prior physical injuries we need to be aware of?
❑ Yes ❑ No

Have you ever suffered from a heat related illness?
❑ Yes ❑ No

Have you ever suffered from a cold related illness?
❑ Yes ❑ No

Hypothermia: ❑ Yes ❑ No
Frostbite: ❑ Yes ❑ No

Heat Stroke: ❑ Yes ❑ No
Heat Exhaustion: ❑ Yes ❑ No

Do you have any food, chemical or medication allergies? Please explain in (Other) if your allergy is not listed.
Shellfish ❑ Yes ❑ No
Chlorine ❑ Yes ❑ No
Penicillin ❑ Yes ❑ No
Other:__________________________________

Do you have any phobias?
Phobia of the Dark: ❑ Yes ❑ No
Phobia of Heights: ❑ Yes ❑ No
Phobia of Snakes: ❑ Yes ❑ No
Phobia of Spiders: ❑ Yes ❑ No
Are you Claustrophobic: ❑ Yes ❑ No

Other: ____________________________

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Student:	Home Phone: ( )	Work Phone: ( )

The above information is true to the best of my knowledge. It is understood that I am financially responsible for any medical treatment. I also understand that VINCO Group, LLC requires knowledge of all students' medical information so that they can provide the best suited training for my health and safety. Personal information will be discarded upon completion of training.

Student/Guardian Signature: *Date*