

Magic Show Participant Health Disclosure Form

Participant Information

Full Name

Date of Birth

Phone Number

Email Address

Emergency Contact

Contact Name

Contact Phone Number

Relationship to Participant

Health Information

Do you have any of the following? (Check all that apply)

☐

Allergies

☐

Asthma

☐

Heart Condition

☐

Epilepsy/Seizures

☐

Takes medication regularly

☐

Other medical condition

If checked, please provide details

List any medications currently taken

Physical restrictions or limitations

Consent and Signature

I confirm that the information provided above is accurate and complete. I acknowledge potential risks and consent to participate in the Magic Show.

Participant Signature

Date