

SUNKEN TREASURE

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Krislund Camp Scuba Participant Form

Please fill out forms 1-3. ALL Medical question must be answered with either a yes or no. Only if you answer yes is a student required to have a physicians signature.

Students Name: _____

Mailing Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

eMail: _____

DOB: Jan ___ Feb ___ Mar ___ Apr ___ May ___ Jun ___

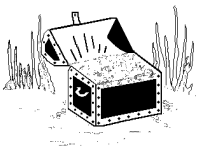
Jul ___ Aug ___ Sep ___ Oct ___ Nov ___ Dec ___ _____ Day _____ Year

Emergency Contact Information

Name: _____

Contact Number: _____

Relationship: _____



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