**Spirit of Healing**

**5115 Olentangy River Road**

**Columbus, OH 43235**

**(614) 326-3504**

**BioScan Intake Forms**

|  |  |
| --- | --- |
| Patient Name: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender: € MALE € FEMALE Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How did you hear about us?­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand.**

* We do not treat symptoms or disease;
* An allergy is not a disease, rather a condition;
* A symptom is an attempt by your body to tell you something;
* We will attempt to find the underlying cause;
* We do not use drugs in this program;
* There is no single “healthy” diet that will work for everyone;
* Just because food is considered “healthy”, does not mean it is “healthy” for you;
* Your diet consists of everything you **eat, drink, rub on your skin, consume, or inhale**;
* Our procedures are safe and painless.

**Briefly describe the reason for your visit and what you hope to accomplish:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGE WHEN SYMPTOMS WERE FIRST OBSERVED:**

|  |  |  |
| --- | --- | --- |
| € Infant (Age 0-2) | € Child Age (Age 3-5) | € Child (Age 6-12) |
| € Adolescent (Age13-18) | € Adult (age 19-25 | € Adult (Age 26-40) |
| € Adult (Age 41 and over) |  |  |

**PREVIOUS ALLERGY EVALUATION:**

|  |  |  |
| --- | --- | --- |
| **Have you ever seen an allergist?**  | € Yes | € No |
| **Have you had allergy skin testing?**  | € Yes | € No |
| **Did you have any positive reaction?**  | € Yes | € No |
| **If yes, please list positive allergens (including any medications):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Have you ever received allergy injections?** Yes \_\_\_ No \_\_\_ |

**WORK ENVIRONMENT:**

**What is your occupation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you exposed to chemicals or strong odors at work?** Yes\_\_\_ No\_\_\_

**If yes, briefly explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are your symptoms worse while at work?** Yes\_\_\_ No\_\_\_

**If yes, briefly explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any additional information you would like us to know?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WHEN ARE YOUR SYMPTOMS WORSE:**

 € Year round

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| € January | € February | € March | € April | € May  | € June |
| € July  | € August | € September | € October | € November | € December |

**MEDICATIONS:**

|  |
| --- |
| **Do you take any of the following medications on a regular basis?** |
| € Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax Claritin, Allegra, Zyrtec, etc.) |
| € Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS’s such as Primatine Mist, etc.) |
| € Steroid inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair etc.) |
| € Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc.) |
| € Medication that affects the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc.) |
| € Chemotherapy |
| € Other, please list any medications that you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SMOKING:** |
| **Do you smoke?** Yes\_\_\_\_ No\_\_\_\_ **Number of cigarettes per day** \_\_\_\_ **At what age did you start?** \_\_\_\_\_ **Does** **Anyone smoke in your house?** Yes\_\_\_\_ No\_\_\_\_ |
|

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| --- |
| **FOOD RELATED SYMPTOMS:** |
| € Symptoms flare 5-60 minutes after meals € Some foods are craved or addictive |
| € The smell or odor of some foods increases symptoms |  € Some foods cause nasal symptoms |
|  |  |
| € Some foods cause swelling of the mouth or tongue  |  € Some foods cause rashes or hives |
| € Some foods cause upset stomach or vomiting |  € Some foods cause diarrhea |
| € Symptoms occur with restaurant salad bars or Asian foods |  € Some foods cause headaches |
| € Symptoms occur with any regularly eaten food |  € Some foods cause asthma |
| € Preservatives, additives or food coloring increases symptoms |  € No problem with foods |

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**FOODS THAT CAUSES SYMPTOM FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| € Eggs | € Milk | € Beef | € Corn | € Wheat | € Soybean |
| € Peanut | € Pork | € Fish | € Shellfish | € Orange/citrus | € Potato |
| € Tomato | € Yeast | € Chocolate | € Coffee/Tea  | € None | € Other |
|

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| **CHEMICALS THAT CAUSE SYMPTOMS:** |
| € Insecticides & pesticides | € Paints &household cleaners | € Perfumes & cosmetics |
| € Gasoline & auto exhaust | € Stove or furnace emissions | € The smell of new fabrics or fabric store |
| € Chemicals in the work place | € Laundry detergent | € Newsprint |
|  |  |  |

 €Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_€ None |
| **Did you suffer from any type of physical, chemical or emotional trauma just before your symptoms were first observed?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Have your symptoms ever gone away for any period of time?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PREVIOUS DIAGNOSIS OF ALLERGY? FAMILY MEMBERS WITH ALLERGIC SYMPTOMS**€ Yes, and allergy shots helped € Mother € None € Did not help € Father € Yes, medication helped € Brother/Sister € Did not help € Son/Daughter € None € Spouse

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| --- |
| **FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS:** |
| € Constant/Chronic with little change € Present part of the time € Present most of the time€ Present some with normal life€ Present rarely normal activities |  |
| € Slight interference |  |
| € Interference with normal life  |  |
| € No interference with normal life |  |

 |  |  |
| **SYMPTOMS ARE WORSE:**

|  |  |
| --- | --- |
| € Outdoors and better indoors | € At nighttime |
| € In the bedroom or when in bed | € During windy weather |
| € During wet or damp weather | € When the weather changes |
| € During known pollen seasons | € In certain rooms or buildings |
| € When exposed to tobacco smoke | € With yard work, cut grass, leaves, hay or barns |
| € When sweeping or dusting the house | € In areas with mold or mildew |
| € In air conditioning | € In fields or in the country |
| € Tobacco smoke bothers me more than anything else |

 |  |  |
| **SYMPTOMS ARE BETTER:**

|  |  |  |
| --- | --- | --- |
| € After shower or bath | € In air conditioning | € Indoors |
| € During or after physical activity | € After taking antihistamines | € With allergy shots |

**What makes you feel better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ANIMAL, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE:**

|  |  |  |
| --- | --- | --- |
| € Dogs | € Cats | € Horses or Cattle |
| € Rabbits | € Birds or Feathers | € Rodents (mice, guinea pigs…) |
| € Bees | € None | € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| **Have You Been Vaccinated Against Communicable Diseases?** Yes\_\_\_\_ No\_\_\_**Have You experienced any adverse reactions or symptoms after vaccination administered?**Yes\_\_\_\_ No\_\_\_\_**At What Age were symptoms / reactions experienced?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Name of Vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(age in months, years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(age in months, years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Name of Vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(age in months, years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU**

|  |  |  |
| --- | --- | --- |
|  **Digestive Tract** | **Heart** | **Nose** |
| € nausea & vomiting /diarrhea | € irregular/skipped heartbeat | € stuffy nose |
| € blood and/or mucous in stools | € rapid/pounding heartbeat | € chronically red/inflamed nose |
| € constipation | € chest pain | € sinus problems |
| € bloated feeling |  | € fever |
| € stomach pains or cramps | **Joints & muscles** | € sneezing attacks  |
| € heart burn | € pain/ache/swollen/tender joints/ muscles | € excessive mucous formation |
| **Ears** | € arthritis/osteoarthritis | **Skin** |
| € itchy ears | € stiffness/limited movement | € acne |
| € earaches/ear infections | € feeling weak/tired | € itching |
| € drainage from ears | € psoriatic/gouty arthritis | € hives/rash/dry skin |
| € ringing in ears |  | € hair loss |
| € hearing loss | **Lungs** | € flushing/hot flashes |
| € reddening of ears | € chest congestion |  |
|  | € asthma/bronchitis | **Weight** |
| **Emotions** | € shortness of breath | € binge eating/drinking |
| € mood swings | € difficult breathing | € craving certain foods |
| € anxiety/fear/nervousness | € persistent cough | € excessive weight |
| € anger/irritability/aggressiveness | € wheezing | € water retention |
| € argumentative |  |  |
| € frustrated/cries easily | **Mind** |  |
| € depression | € poor memory | **Genitourinary** |
|  | € difficulty completing projects | € kidney |
| **Eyes** | € difficulty with mathematics | € frequent/urgent urination |
| € watery or itchy eyes | € poor/short attention | € bladder |
| € red/swollen/itchy eyelids | € confusion | € yeast infections |
| € bags or dark circles under eyes | € easily distracted | € genital/ anal itching/discharge |
| € blurred or tunnel vision | € difficulty making decisions |  |
|  | € learning disabilities |  |
| **Mouth & Throat Thrush** |  |  |
| € gagging/clearing throat often |  |  |
| € sore throat/hoarse voice/voice loss |  |  |
| € swollen/discolored tongue/lips |  |  |
| € cancer sores |  |  |
| € itching on roof of mouth |  |  |
| **Head:**€ headaches | **Other Conditions:**€ Autism |
| € faintness | € A.D.H.D. |
| € dizziness | € A.D.D. |
| € insomnia/sleep disorder | € Psoriasis |
| € facial flushing | € Eczema |
|  | € Auto Immune Disorder |
|  | € Chronic Fatigue |
|  | € Multiple Chemical Sensitivities |
|  | € Asthma |
|  | € Congestive Heart Failure |
|  | € Sever Diabetes |
|  | € Severe Depression |
|  | € Obsessive Compulsive Disorder |

**Symptoms of Hypothyroidism:**

|  |  |
| --- | --- |
| € Fatigue, sluggishness or weakness | € Swelling of the arms, hands, legs, and fee |
| € Dry skin  | € Facial puffiness, especially around the eyes |
| € Brittle nails | € Hoarseness |
| € Hair loss and/or coarse or dry hair | € Muscle aches and cramps |
| € Increased sensitivity to cold | € Low blood pressure  |
| € Constipation | € Elevated blood cholesterol |
| € Memory problems or having trouble thinking clearly | € Infertility |
| € Heavy or irregular menstrual periods  | € Sleep irregularities |
| € Weight gain | € Depression |

**INFORMED CONSENT FOR THE BIOSCAN** **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Background:** I desire to be tested to determine possible undesirable reactions to various stressors that are natural constituents of my diet, environment, or body chemistry. I understand that the device being used is FDA cleared for Galvanic Skin Response Testing and not intended to directly treat or cure any specific condition, symptom, or illness. The practitioner has explained, and I understand, the benefits of receiving stress reduction and relaxation therapy and the direct relationship between stress, illness, and disease. \_\_\_\_ **(initial here)****Procedures:** I understand that this is a non-invasive procedure (the skin is not pierced). A stylus or electrodes are attached to the skin to measure electrical conductivity on the hands. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of the immune system and related symptoms are unpredictable and therefore the facility cannot guarantee any results. **Spirit of Healing LLC** cannot guarantee that new stressors will not contribute toward my health conditions in the future and that in some cases a person may not wholly respond to the treatment.\_\_\_\_ **(initial here)** I am choosing to be tested with the Bioscan. \_\_\_\_ **(initial here)** I understand that this testing has not been scientifically proven to be reliable and that my practitioner must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test. \_\_\_\_ **(initial here)****Risks:** The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk of electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium if those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your practitioner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your practitioner. I understand that there is a risk factor where, because of exposure to these bio-energetic stressors, I may experience temporary symptoms not unusual to the regular symptoms currently experienced when exposed to these stressors. **\_\_\_\_ (initial here)** I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. \_\_\_\_ **(initial here)**I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of patients suffering from anaphylactic allergic reactions and I agree to completely disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis. \_\_\_\_ **(initial here)****Questions:** I have been provided with the opportunity to ask any pertinent questions I have regarding the BioScan procedure, protocol, or treatment program. \_\_\_\_ **(initial here)****Free to Decline:** I understand that I may decline to the BioScan testing and Processing. \_\_\_\_ **(initial here)****Important:** There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your practitioner may recommend other forms of testing during your treatment, referring you to your physician or other healthcare practitioners. **Payment of Services:** You are responsible for the payment of the normal and necessary fees associated with the BioScan Assessment and services performed as a result of that testing. If products are recommended, you are responsible for purchasing those products. However, purchasing products is not a requirement of participation in scanning/assessment. I have read and understand the above information about the BioScan and my rights and responsibilities and hereby consent to the use of the BioScan. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research, and scientific purposes provided that my identity is kept confidential.**Patient’s Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**IF YOU ARE UNDER 18 YEARS OF AGE, WHO ARE YOUR LEGAL PARENTS OR GUARDIAN?****Father:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Mother:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Parent or Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |