Last _______________________________ First_________________________ Middle____________________

Telephone No:_____________________________ Date of Birth: _____________________________

Emergency Contact: ____

PARTICIPANT MEDICAL HISTORY

1. Does the participant have any physical limitations or medical conditions? Yes/ No

List____

2. Are there any recent surgeries or scheduled surgeries? Yes/ No

List____

3. Is there any history of concussions and/or head injuries? Yes /No

4. Is the participant currently taking any medications? Yes /No

List____

5. Does the participant have any allergies (penicillin, bee stings, etc)? Yes/ No

List____

6. Does the participant have asthma/require the use of an inhaler? Yes/ No

7. Is the participant diabetic/require medication for diabetes? Yes/ No

8. Does/has the participant have/had seizures? Yes/ No

9. Does the participant wear glasses or contact lenses? Yes/ No

10. Does the participant wear a brace or other medical support device? Yes/ No

list____

Signature of Parent or Legal Guardian: date

____

Print
Name____

Relationship to
Participant____