

DATE: _____

NAME: _____

EMAIL: _____

ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____

CITY: _____ ZIP: _____

PHONE: _____

GUARDIAN (1): _____

GUARDIAN'S PHONE: _____

GUARDIAN (2): _____

GUARDIAN'S PHONE: _____

EMERGENCY CONTACT: _____

E.C. PHONE: _____

YOUR PHYSICIAN: _____

CLINIC: _____

LIST ANY CURRENT MEDICATIONS YOU ARE TAKING: _____

ANY ALLERGIES WE SHOULD BE AWARE OF: _____

ARE YOU CURRENTLY SEEING A PHYSICIAN: _____ IF YES, EXPLAIN: _____

HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? (CIRCLE ANY THAT APPLY)

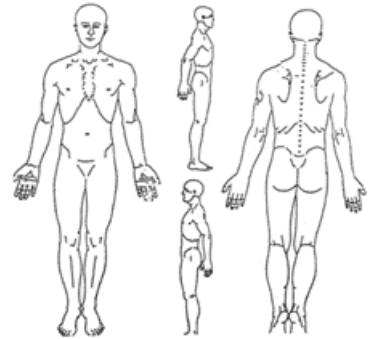
HEART MURMUR / HEART DISEASE / DIABETES / SICKLE CELL ANEMIA / HIGH OR LOW BLOOD PRESSURE / SKIN DISORDER / MIGRAINE HEADACHE / HEAT STROKE
 HEAT EXHAUSTION / FREQUENT SKIN INFECTION / CHRONIC SORE THROAT / CONGENITAL ABNORMALITY / MONONUCLEOSIS / THYROID DISEASE / HIV INFECTION
 SEIZURE DISORDER / RHEUMATIC FEVER / HEPATITIS / SCARLET FEVER / TUBERCULOSIS / ULCER / HEMORRHOIDS / NERVOUS STOMACH / HERNIA / APPENDICITIS
 KIDNEY BLADDER INFECTION / FREQUENT DIARRHEA / LOSS OF AN ORGAN / PNEUMONIA / ARTHRITIS / ASTHMA / CONCUSSION / FAINTING / OTHER: _____

FAMILY HISTORY

FATHER'S AGE: _____	HEALTH: _____	DEATH AGE: _____	CAUSE: _____
MOTHER'S AGE: _____	HEALTH: _____	DEATH AGE: _____	CAUSE: _____
SIBLING'S AGE: _____	HEALTH: _____	DEATH AGE: _____	CAUSE: _____
SIBLING'S AGE: _____	HEALTH: _____	DEATH AGE: _____	CAUSE: _____
SIBLING'S AGE: _____	HEALTH: _____	DEATH AGE: _____	CAUSE: _____

PLEASE LIST ANY BLOOD RELATIVES (PARENT/GRANDPARENT/AUNT/UNCLE) WHO HAVE HAD ANY OF THE FOLLOWING:
 SUDDEN DEATH BEFORE THE AGE OF 50 / CANCER / HEART DISEASE / HIGH BLOOD PRESSURE / STROKE / DIABETES / EPILEPSY

PLEASE DESCRIBE ANY PAST OR CURRENT CONDITIONS YOU HAVE EXPERIENCED:
 (SPRAINS, STRAINS, PAINS, SURGERIES, FRACTURES, ETC.)



ANY OTHER AREA'S RELATED TO YOUR HEALTH THAT YOU WOULD LIKE TO SHARE:

I HEARBY STATE, THAT TO MY KNOWLEDGE, I HAVE GIVEN A CORRECT AND ACCURATE MEDICAL HISTORY REPORT.

ATHLETE SIGN: _____

GUARDIAN SIGN: _____