Medical Information

Athlete Name: ___________________ Birth Date (dd/mm/yyyy) __/__/____Age: ____ M/F ____

Address: ____

Health Insurance # ____

Names of Parents/ Guardians: ____

Telephone: Home: _________________ Work: ________________ Cell: ___________________

Telephone: Home: _________________ Work: ________________ Cell: ___________________

Family Doctor: _____________________________ Phone: _______________________________

Health History Details

Allergies	Yes __ No __	
Asthma (Respiratory)	Yes __ No __	
Blackouts/ Fainting	Yes __ No __	
Chest pain	Yes __ No __	
Diabetes	Yes __ No __	
Epilepsy	Yes __ No __	
Hearing disorder	Yes __ No __	
Heart condition	Yes __ No __	
Recurring headaches	Yes __ No __	
Seizures	Yes __ No __	
Glasses	Yes __ No __	
Contact lenses	Yes __ No __	
Concussion	Yes __ No __	
Other Injuries (specify)	Yes __ No __	
Medications (specify	Yes __ No __	
Other (including recent surgery)	Yes __ No __	