Print Form

Medical History Form

Name:_____ Social Security #:_____
Address:_____ Birthdate:_____
_____ Phone Number:_____
Level/Week Attending _____

Who to contact in case of an emergency

Name:_____ Relationship:_____
Daytime Phone:_____ Evening Phone:_____
Physician's Name / Hospital:_____/_____
Daytime Phone:_____ Evening Phone:_____
Family Dentist: _____ Phone: _____

Allergies, List all known allergies:

Medication:_____
Food:_____
Other(hay fever, asthma, etc.):_____

General Questions, if the answer to any of the following questions is or was 'yes', please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following?

Head injury (Concussion, skull fracture)	Yes	No			
Fainting spells	Yes	No	Measles	Yes	No
Convulsions/epilepsy	Yes	No	Chicken Pox	Yes	No
Neck or back injury	Yes	No	German measles	Yes	No
Asthma	Yes	No	Mumps	Yes	No
High blood pressure	Yes	No	Hepatitis A	Yes	No
Kidney problems	Yes	No	Hepatitis B	Yes	No
Hernia	Yes	No	Hepatitis C	Yes	No
Diabetes	Yes	No			
Heart murmur	Yes	No			
Dizziness, chest pains, or passed out after exercise	Yes	No			
Allergies (specify)_____	Yes	No			
Impaired vision	Yes	No			
Impaired hearing	Yes	No			
Other_____					

Injuries to:

Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Wrist, hand, fingers	Yes	No
Arm	Yes	No
Other_____		

Have you had a recent tetanus booster? _____ If so, When? _____
Are you currently taking any medications? _____ If so, What? Why? Dosage? _____
_____
Has a doctor placed any restrictions on your activity? _____ If so, Explain _____
_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health that which the camp should be aware. _____
_____
_____

Signed: _____ Date: _____
(Athlete)
Signed: _____ Date: _____
(Parent/Guardian)