



ATHLETE MEDICAL FORM - PAGE 1

DEMOGRAPHICS

PROGRAM: _____

Athlete's Social Security # _____ - _____ - _____ (if US Citizen) Male Female Date of Birth (month/day/year) _____/_____/_____

Athlete's Name _____

Athlete's Address _____

Parent/Guardian's Name _____

Parent/Guardian's Address (if different than athlete) _____

Emergency Contact (if other than parent/guardian) _____

Health/Accident Insurance Company _____

Athlete's Home Phone # _____

Parent's Work Phone # _____

Parent's Home Phone # _____

Emergency Contact's Phone # _____

Policy # _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy: _____
<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____
<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____
<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____
<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	Special diet _____
<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use _____
<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding _____
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / psychiatric / behavioral _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date _____
Date of most recent tetanus immunization _____/_____/_____			<input type="checkbox"/>	<input type="checkbox"/>	Other _____

(*) Requires physical examination

Medications:

Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed.	Times per day	Medication Name	Dosage	Date Prescribed.	Times per day

Signature of parent/caregiver/adult athlete: _____ date _____/_____/_____