



## Participant Medical History

2018-2019 Season

Today's Date \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Last

First

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone and Contact for Emergencies: \_\_\_\_\_

Present Condition:

Medical Problems:

Medications:

### Other Medical Problems

Vision	
Hearing	
Breathing	
Swallowing	
Digestion	
Heart	
Bones	
Nerves	
Skin	
Infection	
Seizures	
Diabetes	
Allergies	

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip

Physician's Signature: Print \_\_\_\_\_ Sign \_\_\_\_\_