Participant Medical History

2019-2020 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 _____