

Medical Information Form

Fill out this form completely to allow for your participation on the course

Name	Phone	Email
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Parents' Name	Phone	Email
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Address	City	State	Zip
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Date of Birth	Height	Weight
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Emergency Contact	Phone	Relationship to Participant
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Allergies: Do you have any allergic reactions (e.g., to bees, drugs, foods, ect.)? If so, what are they?

Medications: Are you taking medication (e.g., Tylenol, Orthonovo 777, Proventill, ect)? If so, what are they? What are they for? Do you have any medications with you?

Chronic Illnesses: Do you have any chronic illnesses (e.g., diabetes, epilepsy, asthma, ect.)? Please list.

Physical Conditions: Do you have any physical conditions that might limit or prevent you from participating in certain physical activities? If so, please describe such limitations and conditions on activities

Injuries: Have you experienced any injuries (e.g., dislocations, sprains, ect.) within the last three years? If so, list here and identify when the injuries occurred and the extent or the severity of the injury. Have you fully recovered from this injury?

Physician: Have you been treated by a physician in the past year? Have you been hospitalized within the past year? If so, please explain.

Primary Physician: Name, Address and Phone Number

Insurance: By what Insurance Company are you covered? If possible please include your I.D. number