

MEDICAL INFORMATION FORM

Confidential

NAME:	
PARENT/GUARDIAN Signature:	Date:
HEALTH CARE #:	Date of Birth:
PHONE:	EMAIL:
NEXT OF KIN & THEIR PHONE NUMBER:	

MEDICAL HISTORY

Injuries – Please check appropriate box(es) if you have had any of the following injuries:

- Concussions Wrist Hip Neck Fingers Knees Ribs Elbows
 Ankles Back Shoulder Feet Fractures Dislocations Other (list):

Medical Illness – Please check appropriate box(es) if you have had any of the following:

- Mumps Chicken Pox Heart Murmur Palpitations Irregular Heart Beat
 Dizziness Blacking Out Episodes Pain/Pressure in the Chest Stomach Ulcer
 Frequent Heartburn Intestinal Problems Recent Weight Gain or Loss
 Eating Disorder Shortness of Breath with Exercise Asthma Sinus Problems
 Kidney Disease Diabetes Arthritis Frequent Anxiety Depression
 Hearing Impairment Visual Impairment Recurrent Headaches Tumors or Cancers
 Head Injury with Unconsciousness Other

Describe:

Allergies – Environmental [e.g. dust, smoke, hay fever, animals, etc.]

If you have any other type of allergy, please list and include any medication used to treat allergic reactions:

Medications – Prescriptions [list] :
