Medical History Card

Name: _____Birthdate: _____

Address:_____

_____Phone#:_____

Personal Healthcare#_____

Parent/Guardian Name: _____

Address(if different from above):_____

Phone (home):_____Phone (work):_____

Contact (if parent unavailable):_____Phone#:_____

Family Physician: _____Phone #: _____

Record of Illness or conditions, past or present, that may affect or be affected by performance

Asthma ___ Diabetes ___ Heart Disease ___ Seizures ___

Other:_____

_____

Specify other problems, previous injuries or surgery

Headaches ___ Blackouts ___ Chest Pain ___ Fractures ___ # of Concusions ___

Other:_____

_____

Are corrective lenses required: Yes ___ No ___

Immunization: Year of last tetanus shot: _____

List of allergies and medications taken regularly: _____

_____

Date card completed:_____

Signature of parent guardian:_____