

Medical History Card	
Name: _____	Birthdate: _____
Address: _____	
_____ Phone: _____	
Personal Health Number: _____	
Parent/Guardian Name: _____	
Address (If different from above): _____	
Phone (home): _____	Phone (work): _____
Contact person (if parent is unavailable): _____ Phone: _____	
Family Physician: _____ Phone: _____	
Record of Illnesses. State illnesses or conditions, past or present, that may affect or be affected by performance.	
Asthma <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Seizures <input type="checkbox"/>
Other: _____	

(Specify) Other problems, previous injuries or surgery	
Headaches <input type="checkbox"/>	Blackouts <input type="checkbox"/>
Fractures <input type="checkbox"/>	Chest Pain <input type="checkbox"/>
# of Concussions _____	
Other: _____	
Are corrective lenses required No <input type="checkbox"/> Yes <input type="checkbox"/>	
Immunization: Year of last tetanus shot: _____	
List allergies and/or medications taken regularly:	

Date card completed: _____	

Signature of parent or guardian	