LAKELAND LACROSSE MEDICAL HISTORY CARD

Name: ____ Birthdate: __________________________

Sex: ___M ___ F Height: _______ Weight: ________ Age: _____

Address: ____

E – mail____ Phone: ____________________________

Personal Health number: ____

Parent/Guardian Name: ____

Address (if different from above): ____

Phone (home): ______________________ Work: ____________________Cell: ______________________
Contact person
(if parent is unavailable): __________________________________ Phone: __________________________

Family Physician : ____ Phone: __________________________

Record of illness. State illness or conditions, past or present, which may affect or be affected by Performance.
Asthma ____ Diabetes _____ Heart Disease ______ Seizures____ Allergies____
Other : ____

____

(Specify) Other problems, previous injuries or surgery

Headaches_____ Blackouts_____ Chest pain____ Fractures_____ # of concussions _______
Other: ____

Are corrective lenses required No _____ Yes ______ Is an Epipen required No _____ Yes______

Immunization : Year of last tetanus shot ____

List allergies and/or medications taken regularly:

____

Date card completed: ____

____
Signature of parent or guardian