

PERSONAL HISTORY (To be filled out by parent or guardian)

Last Name	First Name	Birth Date
Address		School
Home/Cell Phone Number		Emergency Number
Email Address		

Family Doctor & Phone Number

	Yes	No
1. Are you under the care of a physician for any specific problem? If so, what problem? _____	_____	_____
2. Are you allergic to any medication(s)? If so, what medication(s)? _____	_____	_____
3. Is there a history of Heart Disease or Murmur?	_____	_____
4. Is there any PERSONAL history of diabetes, epilepsy, arthritis, asthma, single kidney, anemia or high blood pressure? (Please circle above if applicable)	_____	_____
5. Do you use an inhaler if you have asthma?	_____	_____
6. Have you ever been knocked unconscious? When? _____	_____	_____
7. Have you ever been diagnosed with a concussion? If so, how many? _____ List approximate date(s): _____	_____	_____
8. Have you ever had surgery? If so, list year and surgery: _____	_____	_____
9. Have you ever had Knee, Ankle or Shoulder injury? (Please circle above if applicable)	_____	_____
10. Have you ever had a back, neck, arm, finger, or toe injury? (Please circle above if applicable)	_____	_____
11. Have you ever been hospitalized for any illness besides surgery? If so list here: _____	_____	_____

I have filled out the above and certify them to be true to the best of my knowledge. I realize that this does not substitute for a regular exam performed by my family doctor. I agree to having my son or daughter examined and to his/her participating in any sport unless otherwise specified here _____

Parent/Guardian Signature _____ Date _____