Medical History Form

Athlete's name (print): _____

Address: _____

Parents Cell: _____Parent Work:_____

Age: _____ Ht: _____ Wt: _____

Physician: _____Physician's Phone:_____

Emergency Contact:_____Phone:_____

Do you have asthma?_____

Any medications, foods, or other substances to which you are

allergic?_____

Please list any injuries and/or hospitalizations you have had in the past 2

years_____

_____

Please list all medications you are currently

taking_____

_____

Do you have ANY other conditions we need to know

about?_____

_____