Faster Athletics

Medical history form

Name			Sport		Grade
DOB		Home#	Height		Weight
Parent/Guardian			Cell#		Work#
Do you currently have, or have you ever had any of the following?					
Yes	No		Yes	No	
		Heart Condition			Arthritis
		Lung/Breathing Condition			Previous Surgery
		Allergic Reaction to Meds			Allergies
		Epilepsy/Seizures			Diabetes
		High Blood Pressure			Bleeding (Hemophilia)
		Hernia/Rupture			Other

If you answered yes to any of the above, please explain:

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Have you ever injured any of the following, including fractures, dislocation, sprains, strains, concussions, bruises? Please indicate if surgery was necessary.

Head/Neck: ____________________

Nose, face, tooth or jaw ____________________

Shoulder, arm or hand ____________________

Back, ribs or abdomen ____________________

Hip, leg, knee, ankle or foot ____________________

Do you wear glasses/contact lenses? __________Yes No__________

Are you currently taking any medications? __________Yes No__________ if yes, please list: ____________________

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*** Signature indicates student has been seen by physician within 2 years and is cleared for activity**

Student signature ____________________

*Parent/Guardian signature ____________________