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:

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:

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

Student signature

*Parent/Guardian signature