Emergency Medical Information

Name: _____ Student ID #: _____
(Last) *(First)* *(M.I.)*

Local Address: _____

Permanent Address: _____

Club Sport: _____ Date of Birth: _____

Email: _____ Phone: (_____) _____-_____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone: (_____) _____-_____

Medical Information *(indicate yes or no and provide additional details where necessary)*

Yes No 1. Do you wear glasses, contacts or protective eyewear?

Yes No 1. Do you have any allergies? *(i.e. medicine, food, or seasonal allergies)*
If yes, list: _____

Yes No 2. Are you currently taking medications *(i.e. prescription and over-the counter)*
If yes, list: _____

Yes No 3. Do you have asthma?
If yes, do you use an inhaler? _____

Yes No 4. Have you ever experienced exercise-related dehydration, heat cramps, or heat stroke?
If yes, please explain: _____

Yes No 5. Have you ever experienced dizziness, passed out, or fainted during or after exercise?
If yes, please explain: _____

Yes No 6. Have you ever had a seizure?
If yes, please explain: _____

Yes No 7. Have you ever suffered a head injury or concussion?
If yes, how many times? _____ When was the last one? _____

Yes No 8. Have you experienced severe sprains or strains? Broken or fractured bones?
If yes, please explain: _____

Yes No 9. Do you have any ongoing medical conditions? *(i.e. diabetes, high blood pressure, epilepsy)*
If yes, please explain: _____

Yes No 10. Do you use any protective or corrective equipment? *(i.e. braces, orthotics, hearing aids)*
If yes, please list: _____

I hereby certify that the medical history information given above is complete and accurate.

Signature: _____ Date: _____