Medical History Card

Name: _____ Birthdate: _____

Address: _____

_____Phone: _____

Personal Health Number: _____

Parent/Guardian Name: _____

Address (If different from above): _____

Phone (home): _____ Phone (work): _____

Contact person
(if parent is unavailable): _____Phone: _____

Family Physician: _____Phone: _____

Record of Illnesses. State illnesses or conditions, past or present, that may affect or be affected by performance.

Asthma ☐ Diabetes ☐ Heart Disease ☐ Seizures ☐

Other: _____

_____

(Specify) Other problems, previous injuries or surgery

Headaches ☐ Blackouts ☐ Chest Pain ☐

Fractures ☐ # of Concunssions ____

Other: _____

Are corrective lenses required No ☐ Yes ☐

Immunization: Year of last tetanus shot: _____

List allergies and/or medications taken regularly:

_____

_____

_____

Date card completed: _____

_____

Signature of parent or guardian