Athlete's Medical History

Athlete's Name:	Date of Birth:

Does your athlete have...	
Heart Conditions	Diabetes
Asthma	Other (please list):
Food Alergies (please list):	
Medication Allergies (please list):	
Glasses	Contacts

Has your athlete ever had...	
Concussion	Head Injury
Seizures (please list last occurrence if applied)	
Chronic or recurring illness (please list)	
Other medical conditions (please list):	

Physician and Hospital Information	
Physician Name:	Phone Number
Preferred Hospital:	

Insurance Information	
Company Name:	Company Address:
Policy Holder:	Policy Number:

Printed Name:

Signature:	Date: