MEDICAL HEALTH INFORMATION

NAME_____

Height _____ Weight _____ Age _____ Health: Excellent ____ Good ____ Fair ___ Poor ___

DO YOU HAVE ANY TEMPORARY OR PERMANENT PHYSICAL DISABILITIES OR HANDICAPS (e.g. BAD BACK, HEART CONDITION)? _____ EXPLAIN ___

_____

Have you had major surgery recently? _____ Explain _____

_____

Have you had a major illness recently? _____ Explain _____

_____

Are you currently taking any prescribed or over-the-counter medication (e.g. cold medicine)? _____ Please state what you are taking and what condition it is for: ___

_____

Do you have any allergies or reactions to medications? _____ Explain _____

_____

Do you have asthma? _____ Describe severity _____

Do you carry an inhaler? _____

DO YOU HAVE ANY OTHER RESTRICTIONS OF ACTIVITIES FOR MEDICAL REASONS? _____ EXPLAIN _____

_____

Person to notify in case of an emergency:

NAME:_____ RELATIONSHIP _____

PHONE: _____ ADDRESS: _____