Name: _____ Student ID #: _____

Local Address: _____

Permanent Address: _____

Club Sport: _____ Date of Birth: _____

Email: _____ Phone: (_____) _____-_____

Name: _____ Relationship: _____

Address: _____ Phone: (_____) _____-_____

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

Yes No 1. Do you have any allergies?

If yes, list: _____

Yes No 2. Are you currently taking medications

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?

If yes, please explain: _____

Yes No 10. Do you use any protective or corrective equipment?

If yes, please list: _____

Signature: _____ Date: _____