

Name _____ Sex _____ Age _____ DOB _____

Grade _____ Sport (s) _____

Permanent Address _____

Personal Physician _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone (H) _____ (W) _____

Explain "Yes" Answers below.
Circle Question you don't know the answers to.

- | | Yes | No |
|---|--------------------------|--|
| 1. Has a doctor ever denied or restricted your Participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or Nonprescription (over the counter medicine or Pills)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, Foods or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out After exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or Pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during Exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told you that you have (CHECK ALL THAT APPLY) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> A heart murmur |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> A heart infection |
| 10. Has a doctor ever ordered a test for your heart? (example, ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died for no apparent Reason? | <input type="checkbox"/> | <input type="checkbox"/> |

