# Athlete Medical Information

**First Name:** _______________Middle Initial____ **Last Name**_______________________

**Club**_________________________________ Gender _________

Address: ______________________________________________________________________

City: ______________________________ State: _________ ZIP: ______________ **Birth date:** _________________

Home Phone :(_____) __________________Cell :(_____) ______________________FAX :(_____) ________________

Email: ______________________________________________Social Security (Tax ID) #: _______________________

**MEDICAL/HEALTH and/or SURGICAL INSURANCE**

Company ____________________________________________________________

Address ____________________________________________________________

Group Name ____________________________Contract _______________________

Policy Holder ____________________________Policy #__________________________

**EMERGENCY NOTIFICATION**

In Case of Emergency contact:

1. Name _______________________PH #____________Email:_______________________

Address:______________________________City_________________State______ZIP________

2. Name _______________________PH #____________Email:_______________________

Address:______________________________City_________________State______ZIP________

**Please check space below any illnesses or conditions you have had.**

____Allergies
____Asthma
____Bone Disease
____Bronchitis
____Bleeding Tendencies
____Chicken Pox
____Congenital Deformities
____Diabetes
____Diverticulosis
____Eczema
____Emphysema
____Epilepsy
____Glaucoma
____Gout

____Heart Disease
____Hemorrhoids
____Hepatitis
____Hernia
____HIV/AIDS
____High Blood Pressure
____Liver
____Malaria
____Measles
____Mumps
____Mononucleosis
____Neuritis
____Pancreatitis
____Polio

____Psychiatric Illness
____Rheumatic Fever
____Rheumatoid Arthritis
____Stomach Trouble
____Stroke
____Tuberculosis
____Ulcers (leg)
____Ulcers (stomach)
____Venereal Disease
____Other: ____________
______________________

____Non Smoker

____Smoker

# of Packs a dav

**OPERATIONS**

| Type of Surgery | Month/Year | Name of Hospital |
| --- | --- | --- |
| | | |
| | | |
| | | |

**ALLERGIES** Please check below if you are allergic to the following:

____Penicillin ____Sulfa ____Codeine ___Other
____Demerol ____Aspirin ____Morphine ____________

Please list any other allergies: ______________________________________________________________

List all current medications/vitamins/supplements you are currently taking:

______________________________________________________________________________

______________________________________________________________________________

**I ______________________________________________, verify that all the above information is true.**

Print Name

**Athlete Signature _________________________________________Date ____________________**

**Parent/Guardian Signature (18 & Under) ____________________________________________**