Name: _____ Camp: _____ Date of Birth: _____

General Medical Information

Please indicate if you or a family member have or has had any of the following illnesses or disorders. Please check yes or no. If yes, indicate self or family.

	YES	NO	Self	Family	Date(s}
Mononudeosis					
Hepatitis					
Asthma					
Diabetes					
Epilepsy or Convulsive Disorder					
Anemia (including Sickle Cell)					
Heart Disorder					
Respiratory Disorder					
Kidney Disorder					
Gastrointestinal Disorder					
Eye, Ear, Nose Disorder					
Other Organ Disorder					
Absence of a Paired Organ					
Concussion How many?					
Frequent or Severe Headaches					
History of Fainting					
High Blood Pressure					
Thyroid Disease					

Heat Stroke or Illnesses

Orthopedic Information

				Date
Foot	Yes	No	Surgery	
Ankle	Yes	No	Surgery	
Low Leg	Yes	No	Surgery	
Knee	Yes	No	Surgery	
Thigh	Yes	No	Surgery	
Hip	Yes	No	Surgery	
Spine	Yes	No	Surgery	
Chest	Yes	No	Surgery	
Shoulder	Yes	No	Surgery	
Upper Arm	Yes	No	Surgery	
Elbow	Yes	No	Surgery	
Forearm	Yes	No	Surgery	
Wrist	Yes	No	Surgery	
Hand	Yes	No	Surgery	
Head	Yes	No	Surgery	
Neck	Yes	No	Surgery	
Other	Yes	No	Surgery	

Explanations: _____

1 Do you wear eyeglasses or contact lenses during participation? ☐ YES ☐ NO

2 Do you wear any type of dental appliances? ☐ YES ☐ NO

3 Do you have any known allergies? ☐ YES ☐ NO

4 If yes, please list: _____

4. If yes, please list: here and/or below:

5. Do you currently take any medications? ☐ YES ☐ NO

6 Do you have any other type of illness/condition/injury that we should be aware of? YES NO

If yes, please explain:

I declare the above information is accurate and current.

Signature: _____ Date: _____