MEDICAL HISTORY

Last Name First Name Sport Birth Date Age

Address City State Zip SCC ID #

Email address Home phone # Cell phone #

Medical Insurance Company Insurance #

Have you ever had or do you currently have any of the following conditions:

YES	NO		YES	NO	
	/	Anemia		/	Hepatitis
	/	Asthma		/	Hernia
	/	Appendicitis		/	Hospitalized
	/	Bronchitis		/	Kidney Conditions
	/	High Blood Pressure		/	Mononucleosis
	/	Blood in Urine		/	MRSA
	/	Concussion		/	Cramping/Dehydration
	/	Contacts/Glasses		/	Nervous Breakdown
	/	Exercise Sudden Death (Relative)		/	Pneumonia
	/	Dizziness or Fainting		/	Rheumatic Fever
	/	Epilepsy or Seizures		/	Sinusitis
	/	False teeth or bridges		/	Stomach pain or ulcers
	/	Hay Fever		/	Tetanus shot
	/	Frequent Headaches/Migraines		/	Tonsillitis
	/	Heart Murmur/ Conditions		/	Unconsciousness/Blackouts

EMERGENCY CONTACT INFORMATION:

Name **Relationship** **Cell Phone #** ( )

Address **City** **Home phone#** **Work Phone #**

1st Year Athletes Signature

2nd/3rd Year Athletes Signature