

Participant Medical Information Form

Please complete fully so that instructors can adjust program activities as needed to meet you needs. This information is confidential and will be shared only with medical care providers if necessary.

Name: _____

Address: _____

Phone: _____ Email: _____

Age: _____ Height: _____ Weight: _____

Name & Phone Number of emergency contact: _____

Name & Phone Number of primary care physician: _____

Medical History: Please check each entry.

	YES	NO		YES	NO
High Blood Pressure			Shortness of Breath		
Heart Disease			Arthritis		
Seizure Disorder			Circulation Issues		
Asthma			Orthopedic Issues		
Diabetes			Vision Impairment		
Osteoporosis			Hearing Impairment		
Allergies					

Please explain any "yes" answers in the space below.

Other: Please explain anything that has not been covered. If none, please write "NONE".

Exercise: What type of exercise do you do? How often do you do it? _____

I declare that the information provided is complete and correct. If any information is not disclosed I fully understand that my participation may be terminated. In case of illness or injury, I give my permission to be treated.

Name: _____ Date: _____

Signature: _____