Medical/Surgical Care/Emergency Treatment & Personal Medical Information

Please print Clearly

Name	
Home Address	
Home Telephone	Mobile Phone

Name of Health Insurance Carrier	
Identification Number	Group Number

Are you currently taking any Prescription and Non-Medication Yes_____ No_____ if yes, please explain:	
Anti-Inflammatories	Muscle Relaxtion
Pain Medication	Other
Allergies, if any, please identify	

Do you now have or have you ever had ANY of the following? Please check Yes or No

	Yes	No		Yes	No
Asthma, Bronchitis or Emphysema			Severe or Frequent Headaches		
Shortness if Breath/Chest Pain			Vision or hearing difficulties		
Cancer or Chemotherapy/Radiation			Numbness or tingling		
Any Pins or Metal Implants			Hernia		
Joint Replacement			Arthristis/Swollen Joints		
Back injury/Surgery			Blood Clot/Emboli		
Neck Injury/Surgery			Diabetes		
Elbow/hand injury/Surgery			Dizziness or fainting		
Knee Injury/Surgery			Anemia		
Leg/Ankle/foot/Surgery			Epilepsy/Seizures		
Any other Surgery			Heart attack		
			Stroke/TIA		
			High Blood Pressure		
			Concussion (if yes, when?)		

if you check "YES" on for any item, please explain:
List any other information that would assist us in your care:

Parents Signature	Date