Participant Health Form

Participant's Name ____
Last First Middle

Participant's Date of Birth: ________/________/__________Gender: ______________________

Participant's Address: ________________________________City: ____________________ State: _____

Name of Mother or Legal Guardian: ___________________________ Phone: ______-______-________

Name of Father or Legal Guardian: ___________________________Phone: ______-______-________

Emergency Contact: ______________________________________Phone: ______-______-________

Condition	Yes	Comments	Condition	Yes	Comments
Allergies			Diabetes		
Asthma or breathing problems			Head or spinal injury		
Attention-Deficient/Hyperactivity Disorder			Hearing problems or deafness		
Behavioral problems			Heart problems		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Speech problems		
Cerebral Palsy			Surgery		
Cystic Fibrosis			Vision problems		

Describe any other important health related information about your child (for example, hearing aid, etc.):

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____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

____

Please provide your child's primary physician and/or healthcare provider information:

Family Physician: ___________________________ Phone: ______________________________

Address: __________________________________

Parent/Guardian Signature ________________________________Date: _______/________/ __________