YWCA MEDICAL HISTORY FORM

Athletes
Name____________________________________Birthdate________________Age______________

1. Do you have any injuries requiring medical attention or have you had surgery in the last 12 months?
(Please circle yes or no)
Yes No
If YES, Please describe____

____

2. Do you have any known allergies? Yes No
If Yes, Please describe____

3. Are you under a physician's care or taking medication? Yes No
Please explain____

4. Do you wear contacts? Yes No

5. When was the date of your last tetanus booster?____

6. Have you ever been dizzy or passed out during or after exercise? Yes No

7. Have you ever had a concussion? Yes No

In case of emergency, parents can be reached at the following numbers:
Please indicate home, office or cell numbers
List the number first that you are most likely to be reached.

Number___________________________

Number___________________________

Number___________________________

In case parents cannot be contacted please call:

Contact Name___________________________Number___________________________________

Contact Name___________________________Number___________________________________

Please return this form with your Season Registration form and fees to:
The YWCA, 424 N. Main Street, Greensburg, Pa 15601