General Health Form

First Name: _____ Last Name: _____
DOB: ___/___/_____ Male: ____ Female: ____

Emergency Contact: _____
Phone: _____

Physician Name: _____
Physician Address: _____
Physician Phone: _____

Allergies:

Are you allergic to any Medications? No: _____ Yes: (please list) _____

Are you allergic to any Food? No: _____ Yes: (please list) _____

Do you have any Other allergies? No: _____ Yes: (please list) _____

Other:

Do you have any limitations or restrictions that would prevent you from participating in any physical activities?

No: _____Yes: (please explain) _____

Are there any other Medical or Additional information our staff should be aware of?
(ex: Dietary, Disability, Major operations, Special precautions, Seizures, Emotional concerns)

No: _____ Yes: (please explain) _____