

LEAMINGTON BOXING ACADEMY

Medical Information Form

Name: _____ Health Card #: _____

Address: _____

E-mail: _____ Date of Birth: _____

Home phone: _____ Cell phone: _____

Would you like to be included in our Yahoo Group for e-mail alerts? Yes No

Personal Information

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Emergency

Physician's Name: _____ Phone: _____

Allergies to drugs or foods?: Yes No

If yes, please specify: _____

Are you taking any prescription drugs? Yes No

If yes, please specify drug(s) and reason(s) prescribed: _____

Do you wear contacts or glasses? Yes No

Do you wear a Medic Alert bracelet? Yes No Reason: _____

Have you had, or do you currently have, any of the following?

Arthritis or rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dislocating shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lock knee	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes to "Other issues", please specify on back...		

What medications, if any, should participant have on hand during training? _____

_____ Who should administer it? _____

Medical Information

Participant's signature



Witness' signature

Parent/Guardian's signature (if applicable)

Date