



Sculling Clinic

Athletic Participation Health History Form

You will not be able to participate without submission of both the Health History and Medical Release forms.

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

SOCIAL SECURITY: _____ PHONE: _____

Do you know how to swim? Please check YES _____ NO _____

Please respond to the following bullet points by circling yes or no.

Do you have now or have you had in the past problem with: If yes, please explain

- | | | |
|--|-----|----|
| • Headaches-needing treatment | YES | NO |
| • Heart | YES | NO |
| • Breathing (Asthma) | YES | NO |
| • Abdominal Pain | YES | NO |
| • Epilepsy | YES | NO |
| • Eyes (except glasses) | YES | NO |
| • Hearing or ears | YES | NO |
| • Diabetes | YES | NO |
| • High blood pressure | YES | NO |
| • Allergies | YES | NO |
| • Sickle Cell Anemia or trait | YES | NO |
| • Broken Bones | YES | NO |
| • Concussion | YES | NO |
| • Spine or neck injury | YES | NO |
| • Kidney disorders | YES | NO |
| • Loss of consciousness | YES | NO |
| • Any injury that required hospitalization | YES | NO |

The foregoing information is accurate to the best of my knowledge. I am aware that inaccuracies or omissions may jeopardize my health.

Signature: _____ Date: _____

Emergency Contact and Insurance Information

Person to contact in an emergency: _____

Relationship: _____ Phone: _____

Medical Insurance Company/Plan: _____

Phone: _____ ID/Subscriber: _____

Policy #: _____

Address where claims should be mailed: _____

Please attach a copy (front and back) of the insurance identification card.