Student's Medical Information

(to be completed by all adult students or parents/guardians of students under 18 years of age)

Basic Information

Student's Name: _____ Birthdate: _____

Parent's Name: _____ Date: _____
(if student is under 18 year of age)

Address: _____
City State Zip

Phone Number's: ( ) _____ ( ) _____ ( ) _____
Home Work Other

Employer: _____

Insurance Carrier: _____ Group Number: _____

Contact in case of emergency:

Name: _____ Relationship: _____

Home Phone: ( )_____ Work Phone: ( ) _____

Medical History: Has the student had any of the following?

General Conditions: Circle One			*date*
1. Fainting Spells/Dizziness	yes	no	_____
2. Headaches	yes	no	_____
3. Convulsions/epilepsy	yes	no	_____
4. Asthma	yes	no	_____
5. High blood pressure	yes	no	_____
6. Kidney problems	yes	no	_____
7. Intestinal disorders	yes	no	_____
8. Hernia	yes	no	_____
9. Diabetes	yes	no	_____
10. Heart disease/disorder	yes	no	_____
11. Dental plates	yes	no	_____
12. Poor vision	yes	no	_____
13. Poor hearing	yes	no	_____
14. Allergies	yes	no	_____
Specify: _____			
_____			
15. Joint dislocations:	yes	no	_____
Specify: _____			
_____			
16. Serious/significant illness	yes	no	_____
Specify: _____			
_____			
17. Other:			_____
Specify: _____			
_____			

Injuries: Circle One			*date*
1. Toes	yes	no	_____
2. Feet	yes	no	_____
3. Ankles	yes	no	_____
4. Lower Legs	yes	no	_____
5. Knees	yes	no	_____
6. Thighs	yes	no	_____
7. Hips	yes	no	_____
8. Lower Back	yes	no	_____
9. Upper Back	yes	no	_____
10. Ribs	yes	no	_____
11. Abdomen	yes	no	_____
12. Chest	yes	no	_____
13. Neck	yes	no	_____
14. Fingers	yes	no	_____
15. Hands	yes	no	_____
16. Wrists	yes	no	_____
17. Forearms	yes	no	_____
18. Elbows	yes	no	_____
19. Upper arms	yes	no	_____
20. Shoulders	yes	no	_____
21. Head	yes	no	_____
22. Other			_____
Specify: _____			
_____			

Please elaborate on any of the illnesses or injuries listed above.

_____

_____

_____

_____

_____

This information will remain in the student's confidential file and will be used only in event of an emergency. A copy of this form will

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Circle appropriate response to each question. For each "Yes", please provide additional information.

1. Is the student currently taking any medications?	yes	no	_____
2. Is the student allergic to bee stings, medications, foods, etc.	yes	no	_____
3. Does the student wear any appliances (glasses, contacts, hearing aids, false teeth, braces?)	yes	no	_____ _____
4. Has a physician placed any restrictions on the student's present activities?	yes	no	_____ _____
5. Has the student had any surgical operations?	yes	no	_____
6. Does the student have any existing and/or past medical or emotional conditions that require special concern and attention by a sports coach?	yes	no	_____ _____ _____
7. Does the student have any deformities or handicaps? (curvature of the spine, heart problems, bowed legs, etc.)	yes	no	_____ _____
8. Is there a history of serious family illnesses? (diabetes, bleeding disorders, heart attack, etc.)	yes	no	_____ _____
9. Has the student ever lost consciousness or sustained a concussion?	yes	no	_____ _____
10. Has the student experienced fainting spells or dizziness while exercising?	yes Yes	no no	_____ _____

Does the student have any of the following personal habits? Indicate extent

1. Smoking	yes	no	_____
2. Smokeless tobacco	yes	no	_____
3. Alcohol	yes	no	_____
4. Recreational drugs (marijuana, cocaine, etc.)	yes	no	_____ _____
5. Steroids	yes	no	_____
6. Others	yes	no	_____

Please explain any other concerns that could have implications while teaching the student. Also, describe special first aide requirements, if appropriate.

_____

_____

_____

_____

_____

_____

_____

_____

Signature of student or parent/guardian: _____ Date: _____

This information will remain in the student's confidential file and will be used only in event of an emergency. A copy of this form will accompany the student to the hospital for physician use.

Parental Instruction Concerning Medical Treatment

(to be completed by parents/guardian of students under 18 years of age)

Please read the alternative statements below and sign under the one that you choose.
DO NOT SIGN MORE THAN ONE

1. If my child needs medical attention while participating in TRAPEZE ARTS, Inc. activities, it is my wish that I be contacted before any medical procedures are done on my child, unless immediate treatment is necessary to save my child's life or to prevent permanent injury. I understand that I am financially liable for all costs incurred related to any treatment.

Signature of parent / guardian: _____ Date: _____

2. If my child needs medical treatment while participating in TRAPEZE ARTS, Inc. activities, it is my wish that the treatments begin while efforts are being made to contact me. So treatment is not delayed, I consent to any medical procedures that a physician deems necessary with the understanding that efforts are being made to contact me. I understand that I am financially liable for all costs incurred related to any treatment.

Signature of parent / guardian: _____ Date: _____