Family and Medical Information Form

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

School: ☐ Ben Steele ☐ Castle Rock ☐ Lewis & Clark ☐ Medicine Crow ☐ Riverside ☐ Will James ☐ Senior ☐ Skyview ☐ West ☐ Career Center **Grade:** ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Gender: _____ Birthdate: _____ Email address: _____

Home Address and Zip: _____

Home Phone: _____ Cell Phone: _____

PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____

Home Address and Zip: _____

Email address: _____ Home Phone: _____ Cell Phone: _____

PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____

Home Address and Zip: _____

Email address: _____ Home Phone: _____ Cell Phone: _____

MEDICAL INFORMATION

Family Physician Name: _____ Phone #: _____ Hospital: _____

MEDICAL HISTORY

1. Broken bones? ☐ Yes ☐ No If yes, list bone(s) & year: _____
2. Knee trouble? ☐ Yes ☐ No If yes, when: _____
3. Hip trouble? ☐ Yes ☐ No If yes, when: _____
4. Elbow or shoulder trouble? ☐ Yes ☐ No If yes, when: _____
5. Ever had an operation? ☐ Yes ☐ No If yes, type: _____
6. Bruise or bleed easily? ☐ Yes ☐ No If yes, when: _____
7. Fainting spells or seizures? ☐ Yes ☐ No If yes, when: _____
8. Ever had a concussion? ☐ Yes ☐ No If yes, when: _____
9. Been unconscious as a result of an accident? ☐ Yes ☐ No If yes, when: _____
10. Headaches, particularly after exercise? ☐ Yes ☐ No If yes, when: _____
11. High blood pressure? ☐ Yes ☐ No If yes, when: _____
12. Kidney disease? ☐ Yes ☐ No If yes, when: _____
13. Wear glasses or contact lenses? ☐ Yes ☐ No
14. Diabetes? ☐ Yes ☐ No
15. Current medications and dosages: _____
16. Allergies or reactions: _____
17. Accommodations needed? ☐ Yes ☐ No If yes, select type: ☐ IEP ☐ 504

INSURANCE

If child is covered by family medical policy, please specify below or mark N/A if there is none.

Insurance Company Name: _____ Policy #: _____