Medical History Form 2017-2018

Skater's Name: _____ DOB: _____ Today's date:_____

Past Medical History: Has the child had any of the following Conditions?

Any serious illness or injury? ☐Yes (describe) or ☐No

_____

Asthma? ☐Yes or ☐No

Does your child have an inhaler available if needed?

☐Yes—location of inhaler_____ or ☐Not needed

Heart Problems? ☐Yes, explain_____ or ☐No

Diabetes? ☐Yes or ☐No

Seizures? ☐Yes or ☐No If yes, describe & date of last seizure?_____

_____

Any Allergies & reaction?_____

Does your child have an epi-pen? ☐Yes-Location of epi-pen_____ or ☐No

Any other concerns we should be aware of?

_____

_____

_____

Parent Contact: Name_____Cell#:_____

(Please Print)

Parent Contact: Name_____Cell#:_____

(Please Print)

Emergency contact if unable to contact parent:

Name_____Cell#_____

Parents Signature: _____Date _____

For MSLFSC use only: Reviewed by (initials) _____ Date_____