



Medical Information

Name of Athlete: _____

Please Check Medical Information:

Does the Athlete Have:

- | | | |
|---|----------|---------|
| 1. Heart Problems | Yes_____ | No_____ |
| 2. Diabetes | Yes_____ | No_____ |
| 3. Seizures/Epilepsy | Yes_____ | No_____ |
| 4. Major Surgery/Serious Illness | Yes_____ | No_____ |
| 5. Parent/Sibling (under 40) died of Heart Disease | Yes_____ | No_____ |
| 6. Down's Syndrome | Yes_____ | No_____ |
| If yes, have X-rays of the C1-C2 vertebrae been taken and examined? | Yes_____ | No_____ |
| Date of X-ray_____ | | |
| Does the Athlete have <i>Atlanto-axial Instability</i> | Yes_____ | No_____ |
| 7. Vision Problems/Sight Impaired | Yes_____ | No_____ |
| 8. Hearing Loss/Hearing Impaired | Yes_____ | No_____ |
| 9. Does the Athlete use a wheelchair | Yes_____ | No_____ |
| 10. Does the Athlete use a walker | Yes_____ | No_____ |
| 11. Other | | |

12. Current Medications/Dosage:

13. Allergies: (Medication/Food/Insect Bites, Etc...)

Submit or mail this form with the registration form.

