



Medical History Questionnaire

Name _____

Date of Birth _____ Female _____ Male _____

Address _____ Zip Code _____

Phone # Home _____ Cell _____

E-Mail _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone # Home _____ Cell _____

Visual Diagnosis or Classification _____

All information is Confidential

Are you allergic to any Medication? Yes _____ No _____

List _____

Are you allergic to any foods? Yes _____ No _____

List _____

Are you allergic to insect bites/stings? Yes _____ No _____

List _____

Are you allergic to trees, plants or animals? Yes _____ No _____

List _____

Do you take any over the counter and/or prescription medication? Yes _____ No _____

List _____

Do you take vitamins, minerals, herbs, or other supplements? Yes _____ No _____

List _____



Have you ever been told that you have asthma or exercise induced asthma?

Yes _____ No _____ List Medications _____

Have you ever had a seizure? Yes _____ No _____ Dates _____

Have you ever been told you have epilepsy? Yes _____ No _____

List Medications _____

Are you presently being treated for diabetes or high blood sugar? Yes _____ No _____

List Medications _____

Have you ever been told you are anemic? Yes _____ No _____ Dates _____

Are you being treated for high blood pressure? Yes _____ No _____

List Medication _____

Do you have or have you ever had heart disease (murmur, rheumatic fever or stenosis)?

Yes _____ No _____ List Condition and Dates _____

Do you have or have you ever had liver disease (mononucleosis, hepatitis, etc.)

Yes _____ No _____ List Condition and Dates _____

Have you ever had a shoulder injury, that disabled you for a week or longer (dislocation, separation, surgery, etc.)? Yes _____ No _____ Dates _____

Have you ever had an elbow injury (dislocation, sprain, surgery, etc.)?

Yes _____ No _____

Right _____ Left _____ Dates/what was done _____

Have you ever had a wrist or hand injury (dislocation, sprain, surgery, etc.)?

Yes _____ No _____

Right _____ Left _____ Dates/what was done _____

Have you ever injured your patella, patella tendon, cartilage/meniscus, ligaments or had surgery on your knee? Yes _____ No _____

Right _____ Left _____ List Dates/Procedure _____



Have you ever had an ankle/foot injury that disabled you for a week or more (sprain, strain, dislocation or surgery)? Yes _____ No _____

Right _____ Left _____ List Dates/Procedure _____

Do you presently have a rod, pin, screw or plate anywhere in your body?

Yes _____ No _____ Where _____

Do you wear contact lenses while participating in sports? Yes _____ No _____

Do you wear any removable dental appliance? Yes _____ No _____

Circle those which apply Removable Bridge Retainer Plate

Are you missing one of a set of organs (kidneys, eyes, etc)? Yes _____ No _____

Specify _____

Have you ever had restrictions related to physical activity, or been told by a medical professional that you could not participate in activities related to your physical health? Yes _____ No _____

Reasoning/Dates _____

Do you have any other medical conditions you wish to make us aware of?

THE ABOVE QUESTIONS HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE

Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

* This form was adapted from the Association of Blind Athletes of New Jersey (ABANJ)



PARTICIPATION WAIVER

I acknowledge the existence of risks in connection with my participation in clinics, practice, tournaments, and services provided by St. Joseph's School for the Blind. My participation in these activities is purely voluntary and I elect to participate with full knowledge of the risks of injury or illness. I accept full responsibility for any injuries, illness, and damage to property or equipment that I may sustain in the course of my participation with St. Joseph's School for the Blind.

The risks referred to here may be caused by my own actions or inactions; the actions or inactions of others involved in these activities; or the conditions under which these activities take place.

I acknowledge that engaging in St. Joseph's School for the Blind programs and activities may require a degree of skill and knowledge different from activities with which I have prior experience as a participant. I acknowledge that the coaches and volunteers will attempt to fully explain to me the nature and physical demands of each individual sport, as well as their associated risks, hazards and dangers.

I have read and understand this agreement. I am aware of the level of exertion required to participate in St. Joseph's School for the Blind activities, and I certify that I have the requisite skill and fitness levels to participate in the activities without causing harm to myself or others.

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

St. Joseph's School for the Blind Witness _____ Date _____

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