

# AGA Medical/Health Information

\_\_\_\_\_  
**Participants Name** **Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**Parents Name(s)** **E-mail address** \_\_\_\_\_

\_\_\_\_\_  
**Phone #** **Work #** **Cell #** \_\_\_\_\_

\_\_\_\_\_  
**Emergency Contact Name (other than above)** **Relationship** **Phone #** \_\_\_\_\_

Please list any previous or current conditions or injuries (be specific as to which body part is affected).

## Physical Information

Bones & Joints: \_\_\_\_\_

Muscles: \_\_\_\_\_

Organs: \_\_\_\_\_

Other: \_\_\_\_\_

## Chronic Ailments

\_\_\_\_\_  
Asthma/Respiratory Problems: \_\_\_\_\_

\_\_\_\_\_  
Diabetes: \_\_\_\_\_

\_\_\_\_\_  
Epilepsy: \_\_\_\_\_

\_\_\_\_\_  
Hemophilia/Bleeding Problems: \_\_\_\_\_

Other: \_\_\_\_\_

## Allergies

Insect Bites: \_\_\_\_\_ Foods: \_\_\_\_\_

Medicines: \_\_\_\_\_ Other: \_\_\_\_\_

**Medications regularly taken:** \_\_\_\_\_

**Other medical or physical information:** \_\_\_\_\_

**Participants Physician** \_\_\_\_\_ **Are child's immunizations current?** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

All above information is correct to my knowledge.

**WAIVER ON REVERSE SIDE... MUST SIGN!**