**HEALTH FORM - Confidential**

To be filled out by the participant (or parent if participant is under 18)

**All fields are required;** please indicate if a field is not applicable. If needed, use additional paper.

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| --- | --- | --- | --- | --- | --- |
| **Activity/Program:** | | | | | |
| **Date(s) of Activity/Program:** | | | | | |
| **Participant Name:** | | | Best Contact Number: | | |
| Address: | | | City: | | |
| State: | | | Zip Code: | | |
| Email: | | | Gender: | | |
| Birthdate: | Age: | | Weight: | | Height: |
| Emergency Contact | | | | | |
| Name: | | | Relationship: | | |
| Best Contact Number: | | | | | |
| General Medical History | | | | | |
| Please check any of the following conditions (past or present) that could affect the health and safety of yourself or others during participation in this activity/program:  🞏Yes 🞏No Diabetes or thyroid problems  🞏Yes 🞏No Epilepsy, seizure or convulsions  🞏Yes 🞏No Any problems with vision or hearing; do you regularly use glasses or contact lenses?  🞏Yes 🞏No Headaches, dizzy spells, fainting, blackouts  🞏Yes 🞏No Palpitation of the heart, irregular heartbeat, heart murmurs or cardiac problems?  🞏Yes 🞏No Frequent abdominal cramps, severe menstrual cramps  **Clarifying information on any checked items:** | | | | | |
| Primary Physician’s Information | | | | | |
| Physician Name: | | | Physician Phone Number: | | |
| Muscle/Skeletal Injuries (last 12 months) | | | | | |
| 🞏Yes 🞏No Chronic pain in neck, back, legs, arms, shoulders  🞏Yes 🞏No Broken bones, joint dislocations, serious sprains or weakness of muscles  🞏Yes 🞏No Any severe injury to head, chest or internal organs **Clarifying information on any checked items:** | | | | | |
| Fitness Levels | | | | | |
| Which most closely describes your exercise routine? (circle one) | | | | | |
| Rarely (0-1 times a week) | | Occasionally (2-3 times a week) | | Routinely 4 or more times a week | |
| Medications | | | | | |
| Please list ALL medications (over-the-counter and prescribed), and reason for taking: | | | | | |
| Personal History | | | | | |
| 🞏Yes 🞏No Do you have any disabilities? (Please specify):  🞏Yes 🞏No Do you have any fears or phobias? (please specify):  🞏Yes 🞏No Do you smoke? If yes, how much/often?  🞏Yes 🞏No Do you drink? f yes, how much/often?  🞏Yes 🞏No Do you use illegal drugs or steroids?  🞏Yes 🞏No Are you currently under care of a physician for any reason? (Please specify):  🞏Yes 🞏No Do you have dietary restrictions? (please specify): | | | | | |
| Allergies | | | | | |
| 🞏Yes 🞏No Any known allergies? (IF no, skip to Fitness Levels)  If yes, list all known allergies (Please specify severity of allergic response and level of contact with allergen):  🞏Yes 🞏No Do any of the known allergies cause anaphylaxis? If yes, please list:  Describe the allergic reaction and what should be done to manager it:  🞏Yes 🞏No Will you be carrying an epinephrine auto-injector during this program/activity? Please note this may be a requirement based on the answers in this section. | | | | | |
| Asthma | | | | | |
| 🞏Yes 🞏No Have you ever had any asthma signs/symptoms. If yes, complete rest of this section. If no, skip to “medications”  What induces your asthma? Please be specific:  🞏Yes 🞏No Are you carrying an inhaler with you? Please note this may be a requirement based on the answers in this section. | | | | | |
| Medications | | | | | |
| Please list ALL medications (over-the-counter and prescribed), and reason for taking: | | | | | |
| Other Information | | | | | |
| Is there any other information we should know? | | | | | |
| 🞏Yes 🞏No Does Texas State University have your permission to administer Asprin, Acetaminophen, or Ibuprofen during this program/activity if necessary? | | | | | |
| 🞏Yes 🞏No Does Texas State University have your permission to administer medical assistance during this program/activity if necessary? Please note that this is a requirement for participation in this program/activity. | | | | | |