APPENDIX Q

Medical Profile Form

Name: _____ **Phone #:** _____

Address: _____

Height: _____ **Weight:** _____ **Date of Birth:** _____/_____/_____

Health Card #: _____ **Subscriber's Name:** _____

Allergies to Food or Drugs: _____

_____

Disabilities or Previous Medical Conditions: _____

_____

Emergency Contact:

Name: _____ **Phone #:** _____

Address: _____

Relationship: _____

Please Circle each of the following questions:

Do you have any permanent disabilities?	Yes	No	**If yes, please specify:** _____
Do you wear glasses?	Yes	No	
Do you wear braces or false teeth, bridges, etc.?	Yes	No	
Do you wear a hearing aid or hearing implant?	Yes	No	
Do you wear contact lenses?	Yes	No	
Do you wear a medic alert bracelet?	Yes	No	**If yes, please specify:** _____

Date of last tetanus immunization: _____ **Blood Type:** _____

Have you ever had or, do you have any of the following:

Arthritis or rheumatism	Yes	No	**Headaches**	Yes	No
Asthma	Yes	No	**Heart Trouble**	Yes	No
Chronic Nosebleeds	Yes	No	**Hernia**	Yes	No
Diabetes	Yes	No	**Skin Condition**	Yes	No
Diphtheria	Yes	No	**Stomach Problems**	Yes	No
Dislocating Shoulder	Yes	No	**Swollen/Painful Joints**	Yes	No
Dizziness	Yes	No	**Trick or Lock Knee**	Yes	No
Epilepsy	Yes	No	**Previous Breaks/Sprains**	Yes	No
Fainting	Yes	No			

If you answered yes to any of these, please elaborate: _____

_____

_____

List Medications: _____

Participant's Signature: _____ **Date:** _____

Witness's Signature: _____ **Date:** _____