



MEDICAL HISTORY AND PERMISSION TO PROVIDE TREATMENT

Date: _____

Parents Names: _____

Parents Cell #: _____

Athlete Name: _____

Sex: M or F

Ht: _____ Wt: _____

Address: _____

Number and Street

City

State

Zip

Date of Birth: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact (Name and Telephone): _____

Team or Club: _____

School: _____

Sport(s): _____ Position(s): _____

Health History

Please give us accurate and complete information about your medical history and condition as treatment and training programs or procedures recommended will be based upon this information.

1. Do you have now or have you had in the past, problems with (check **all that apply**):

Headaches Requiring Treatment

Numbness or Tingling

Hearing or Ears

Heart

Operations or Surgery

Varicose Veins

Stroke

Knees

Skin Disorders

Breathing (i.e. Asthma)

Spine

Drug Allergies

Diabetes

Broken Bones

Allergies

Low Blood Sugar/Hypoglycemia

Kidneys

Skin Rashes

Dizzy Spells/Fainting

Bladder

Arthritis

Black Outs

Abdominal Pain

Other Major Injuries

High Blood Pressure

Eyes (except glasses)

Joint Pain or Swelling

Cancer

2. Do you have any problems with the following muscle, tendon, bone or joint areas that you feel could affect your training? (check **all that apply**):

Head

Forearm

Shin

Neck

Wrist

Calf

Back

Hand

Ankle

Chest

Fingers

Foot

Shoulder

Hip

Toes

Upper Arm

Thigh

Elbow

Knee

3. If you answered YES to any of item in questions 1 or 2, please provide details, including any surgeries:

4. Have you ever become ill from exercising in the heat? Specify, please.

5. Have you ever been knocked unconscious and/or had a seizure? Specify, please.

6. Have you been advised to wear a brace or harness during sports? Specify, please.

7. Have you ever been advised by a physician to avoid any type of exercise? Specify, please.

8. Are you currently participating in a regular exercise/training program? Specify, please.

9. Do you smoke? _____ If yes, how much? _____

10. Are you presently taking any prescription medications?

Please List: _____

11. Do you take any over-the-counter medications on a regular basis? Please include vitamins and dietary supplements.

Please List: _____

12. Are you pregnant now or have given birth within the last 6 months? Yes No

13. Date of last physical exam: _____

14. Any other medical conditions or complications we should be made aware of? Specify, please.

PERMISSION TO PROVIDE MEDICAL TREATMENT FOR A MINOR

I HEREBY give my permission for my son/daughter, _____, to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in any training at AROC Sports Training, LLC. I understand that the personnel of AROC Sports Training, LLC will perform only those procedures, which are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate injuries. I authorize AROC Sports Training, LLC staff the right to administer first aid and/or CPR in the event of a situation that requires such intervention, based on the judgment of the AROC Sports Training, LLC staff. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

____ I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment for a Minor Agreement.

I acknowledge that the participant is under the age of 18. I have reviewed the information provided and certify it to be true and correct.

I consent to _____ participating in the evaluation and program.

Signature

Date

Print Name