# Medical Information

Indicate medications(s) which is/are taken on a regular basis:
**Note: participant should bring an adequate supply of their medication(s) with them**
_Name of Medication_____ Dosage_____ Prescribing Physician_____

Name of Medication_____ Dosage_____

Prescribing Physician_____

Is there a medical History involving any of the following: Yes No _

Allergies_____ Heart Disease_____ Phobias of Fears_____ Past injuriesIllness_____ _Past Operations_____ Epilepsy/Seizure _____Disorder___ Convulsions _____ other _____ _

If you answered yes for any of the above conditions please explain in detail, attach another sheet if necessary.

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Please advise of any special instructions, side effects or emergency procedures

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Date of last tetanus booster _____

Participants Signature_____Date_____

Parent/Guardian Signature_____ Date _____