Aggieland Athlete Medical History Form

(Please complete one form for each youth participating in XC/Track)

Athletes Name_____DOB _____

Age _____ *Check one:* M ___ F ___ Current Grade _____

Parents/Guardian Name _____
StreetAddress_____ City_____
State _____ Zip _____
Phone(Daytime) _____
Phone (Nighttime) _____
If Parent/Guardian not available
for emergency, please notify:
Name_____Relationship_____
Preferred Phone _____

CURRENT YOUTH HEALTH/ALLERGY HISTORY (check, if applicable)

Ear Infection ___	Hay Fever ___	Chicken Pox ___	Poison Ivy ___
Heart defect/disease ____	Measles ____	Convulsions ___	Asthma ____
Diabetes ___	German measles ___	Insect Sting ___	Penicillin ___
Mumps ___	Latex ____	Food _____	

Others _____
Please explain any checked above:
_____
Athlete Carries: Epi-pen _____ Inhaler _____ Other _____
Have you had a yearly physical or wellness check in the past year? (Date) _____
Any concussions or unconsciousness (Dates) _____
_____
Any Bleeding disorders _____
Other (please explain)
_____
Date of last Tetanus shot? _____
Surgery/Serious Injuries (Dates) _____
_____
Chronic/Recurring Illness _____
_____
Name of Family Physician _____ Phone _____
Do you carry Family Medical/Hospital Insurance? Yes _____ No _____
If yes: Name of Carrier _____
Policy # _____ Address of Carrier _____
Hospital preference for B/CS _____

Parent Signature / Date: _____
Student Signature / Date: _____
Coach's Signature / Date: _____