

CRUSADER Health History Form

Athlete Name:			
Parent/Guardian:			
Address:			
Phone:	Home:	Work:	Mobile:
Birthdate:	Athlete Social Security #:		
Emergency Contact:	Name:		
	Address:		
	Phone:		
	Relationship to Athlete:		
Current Medications:			
Name of Physician:		Phone:	
Name of Dentist:		Phone:	
Family Medical Insurance:			
Policy/Group #:			
Name of Insured:			
Medical Conditions:			
Allergies:			
Immunization History:			
Date	Vaccine	Date	Vaccine
	DPT		Rubella
	Tetanus/Diphtheria		Hemophilus Influenza B
	Tetanus		Hepatitis B
	Polio		Date of last TB Mantox
	Measles		Result:
List any condition requiring special care, medication or diet:			
Date of last physical:			
Any problems noted?			

Authorization for Treatment: I hereby give permission to the medical personnel selected by the Crusaders to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child/me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Crusaders in charge to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off-site.

Signature of parent/guardian of minor: _____

Signature of minor or of adult participant: _____

This health history is correct so far as I know, and the person herein described has permission to engage in all activities except as noted.

Signature of parent of minor or adult participant: _____