



Creating opportunities. Transforming lives.

MEDICAL AND PERSONAL INFORMATION FORM

Please complete this form accurately and in its entirety so that we can best understand and meet your needs. This information is confidential and will ONLY be shared with the necessary personnel. Failure to complete this form accurately may result in refusal to participate in certain Sportable programs and activities.

Athlete's Name: _____ Gender: M F

Date of Birth: _____ - _____ - _____ Height: _____ Weight: _____ T-Shirt Size: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Athlete E-mail: _____

Parent/Guardian (if athlete under 18): _____

Parent/Guardian E-mail: _____

Parent/Guardian Cell Phone: _____ Work Phone: _____

Emergency Contact Name & Relationship: _____

Emergency Contact Phone: _____ Cell: _____

Health Insurance Provider Name: _____

Policy #: _____ Name of Primary Insured: _____

Athlete's Primary Disability: _____ Date of Onset: _____

If Spinal Cord Injury, what level? _____ Stabilizations (rods/fusion)? _____ Level: _____

Movement or Joint Limitations (dislocations, contractures, etc.) _____

Assistive Device(s) Used for Mobility: _____ Require head support when seated? Y N

Secondary Disability (TBI, visual impairment, ADHD, intellectual disability, etc.) _____

Do you have a supra pubic catheter or colostomy site: Y N Do you have a shunt? Y N

Do you have seizures? Y N Type & Frequency: _____

Are seizures currently controlled? Y N Date of last seizure: _____

Food/Medication/Other Allergies (include latex sensitivity): _____

Do you have any of the following? Check all that apply: _____ Fainting Spells _____ Asthma _____ Heat Sensitivity

_____ Inability to Sweat _____ HIV _____ Hepatitis _____ Diabetes _____ High Blood Pressure

_____ Autonomic Dysreflexia _____ Heart Problems _____ Pressure Sores/Decubiti _____ Other

Please explain any previous conditions you checked: _____

Have you had any surgery in the past 2 years? If yes, please explain. _____

Are you currently under a doctor's care? If yes, please explain _____

Please list all medications currently being taken (attach additional sheet if needed)

- | | | |
|----------------|---------|---------|
| 1. Medication: | Reason: | |
| Side Effects: | | Dosage: |
| 2. Medication: | Reason: | |
| Side Effects: | | Dosage: |
| 3. Medication: | Reason: | |
| Side Effects: | | Dosage: |

Does athlete use any type of assistive device or alternate means of communication? _____

Does the athlete have any other physical, cognitive, social, behavioral, or emotional conditions we should be aware of?
(special diet, short attention span, autism, etc.)

If yes, please describe any behavior modification, reward system, etc. used to enhance the athlete's attention and performance:

Can the athlete swim?

_____ Independently _____ With use of flotation device _____ With physical assistance _____ DOES NOT/has not swam

Authorization for Medical Treatment

I hereby authorize any licensed physician, emergency medical technician, paramedic, nurse, hospital or other first aid or medical health care provider ("Medical Provider") to provide medical care to me or the minor participant for any injury and/or condition that occurs, manifests, or arises at or during any program related activities. I further authorize any Medical Provider to perform all procedures or services deemed medically advisable to treat or relieve complications & unforeseen consequences in any medical treatment, and I knowingly and voluntarily agree to assume such risks for and on behalf of myself and/or said minor. I acknowledge that no warranty is being made as to the result of medical treatment. I agree that I or the minor participant is capable of participating in program activities except as previously noted on this form.

Signature of Participant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____