Health Information Statement

Name: _____ University ID #: _____

Date of Birth: _____ Sex: _____

Home Address: _____

Emergency Contact: _____ Telephone: _____

This information will remain confidential and will be used for official use only.

Have you ever had or do you now have any of the conditions below (check yes or no)?

	Yes	No		Yes	No
Allergies to medications			Eye problems		
Allergies (bee stings, foods, etc.)			Hay Fever		
Significant allergic reaction(s)			Head Injury		
Anemia			Heart/circulatory problems		
Anxiety reactions			Hepatitis/jaundice		
Asthma/respiratory problems			Hernia		
Broken bones			High blood pressure		
Cancer/tumors			Kidney/urinary problems		
Chicken pox			Liver/gallbladder problems		
Chronic Digestive/GI problems			Menstrual problems		
Diabetes			Migraine/chronic headaches		
Dizziness/fainting spells			Narcotic/alcohol dependency		
Epilepsy/seizure disorder			Psychological/psychiatric problems		
Endocrine disorders			Skin disease		
Ear, nose, throat problems			Tuberculosis		

Please explain below if you checked YES for any of the conditions above. Indicate problem, diagnosis if known, if recovery is complete or if you are still under treatment. You may use the space below or attach another sheet.

Have you been in good health during the past 12 months? If NO, please specify:

Are you now taking any medication(s) that you will be bringing with you to try-outs? If YES, please specify:

The above responses are accurate to the best of my knowledge.

Student Signature: _____ Date: _____