Pine Hoops Academy

PERSONAL HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____
Age: _____

Address:
_____
_____

Town/City: _____ State: _____ Zip Code: _____

Home Telephone: (_____)_____ Emergency Telephone Number: (_____)_____

Parent(s)/Guardian(s) Name(s):_____
____

Parent(s)/Guardian(s) Contact Cell Phone Number:
_____

Health Insurance Company:
_____

Health Insurance Number: _____ Group Number: _____

Family Doctors Name: _____ Phone Number: (_____)_____

Please list any ALLERGIES you may have:
_____

Please list any recent INJURIES, which have occurred in the last six months:
_____
_____
_____
_____
_____

Please list any MEDICATION you may take on a regular basis:
_____
_____
_____
_____

_____

Do you suffer from ASTHMA? _____ Do you wear CONTACT LENSES? _____

Do you have any other MEDICAL CONDITIONS that our trainer needs to know about?
_____
_____
_____

PARENT'S/GUARDIAN'S ACKNOWLEDGEMENT: I verify that my child has been checked by a licensed physician prior to coming to Pine Hoops Academy and is physically able to participate fully. I agree to allow my child to be treated by a licensed trainer and/or physician while attending Pine Hoops Academy. In addition, I assume all risks resulting from the participation in this sports camp and will hold harmless Pine Hoops Academy of any and all liability actions, causes of action, claims and demands of every kind and nature whatsoever which may arise in connection with or resulting from participation in any of its activities.

Parent/Guardian:_____ Date:_____