

COMPETITOR & DAN EXAMINEE MEDICAL QUESTIONNAIRE

Every competitor and Dan examinee must sign and submit this medical questionnaire

Name:						
Age:		Gender:	M <input type="checkbox"/>	F <input type="checkbox"/>	Rank:	
Address:						
State:		City:		Zip:		
Club:						
Region:						

Do you have a history of any of the following conditions? Please check all that apply to you. If you answer Yes to any, please explain:

Condition	Yes w/Explanation	No
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>
Bone fracture in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Concussion or severe head injury in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Severe bone bruises requiring padding	<input type="checkbox"/>	<input type="checkbox"/>
Kidney injury	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to medication (list all)	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently taking any medications? (list all) _____

Signature of Competitor: _____ Date: _____

(Parent or Guardian, if under 18 years of age): _____