

OLD DOMINION UNIVERSITY RECREATIONAL SPORTS
1015 W. 47TH STREET
NORFOLK, VIRGINIA 23529

HEALTH INFORMATION FORM

Name: _____

Date of Birth: _____

Name of Mother or Legal Guardian:

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

Name of Father or Legal Guardian:

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

In case of emergency—

If parent or guardian cannot be contacted—contact the following:

1. Name: _____

Relation: _____

Home Phone: () _____ Work Phone: () _____

2. Name: _____

Relation: _____

Home Phone: () _____ Work Phone: () _____

Assessment of Health		
<i>To the best of your knowledge, have you had or currently have problems with any of the following? Please check yes or no. If "yes" please explain.</i>		
Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain
Allergies (seasonal, food, insects, drugs, latex)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma or Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head or Spinal Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalizations (when, why)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscular Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision Problems (Do you wear glasses/contact lenses?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

List all prescription and over-the-counter medications you take regularly:
