

**SAN DIEGO ADAPTIVE SPORTS FOUNDATION
MEDICAL AND PERSONAL INFORMATION FORM**

Please print neatly and complete all areas

Name: _____

Gender: Male/Female Height: _____ Weight: _____ Age: _____ Date of Birth: ____/____/____

Street Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Parents' Names: (mother) _____ (father) _____

Phone: (Home) (____) _____ E-mail: _____

(Mom Cell): (____) _____ (Dad Cell) (____) _____

(Mom Work) (____) _____ (Dad Work) (____) _____

E-mail (mother) : _____ E-mail (father): _____

Emergency Contact: _____ (Home) (____) _____

Physician Name: _____ (Office) (____) _____

Health Insurance Provider Name: _____

Policy Number: _____

Name of Primary Insured: _____

Athlete's Disability: _____ Date of onset: _____

If Spinal Cord injury, what level: _____ Complete / Incomplete Rods: _____

Fusion: _____

Have you had any surgery in the past two years? (Please explain)

Allergies: _____

Do you have seizures? Y/N if yes, are they controlled? Y/N Date of last seizure: _____

Use Catheter? Y/N Briefs: Y/N Schedule (time specific): _____

Assistance: Y/N

Upper Extremity Strength: _____

Lower Extremity Strength: _____

Speech: Intact: ____ Impaired: ____ Hearing: Intact: ____ Impaired: ____

Cognitive: Intact: ____ Impaired: ____ Vision: Glasses / Contacts

Diet Restrictions: _____

Check all that apply:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Metal in Body (screws, implants, etc.) | <input type="checkbox"/> Shunts | <input type="checkbox"/> Automatic Dysreflexia |
| <input type="checkbox"/> Decubiti | <input type="checkbox"/> Seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Grafts | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Unable to sweat |
| <input type="checkbox"/> Heat Exhaustion | <input type="checkbox"/> Prosthetics | <input type="checkbox"/> ADD | |
| | | <input type="checkbox"/> ADHD | |

PLEASE EXPLAIN IF ANY OF THE ABOVE IS CHECKED:

Medications taken (Be specific)	Times Given	Dosage	Self. Admin	Need Asst.

Authorization for Medical Treatment

I hereby authorize any licensed physician, emergency medical technician, paramedics, nurses, hospital, or other medical health care provider (“Medical Provider”) to provide medical care to me or the minor participant for any injury and/or condition that occurs, manifest, or arises at any program related activities. I further authorize any Medical Provider to perform all procedures or services deemed medically advisable to treat or relieve of complications and unforeseen consequences in any medical treatment, and I knowingly and voluntarily agree to assume such risks for and 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 or participating in camp or program activities except as otherwise noted above.

Signature of Participant: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____