DOUGLAS COUNTY MEMORIAL HOSPITAL ATHLETIC PERFORMANCE TRAINING

Athlete's Name: _____ Age: _____ Sex: M F

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Participant email: _____ Parent email: _____

Emergency Contact Person: _____ Phone: _____

Registration Fee: $25
Drop off or mail to:
DCMH, Attn: PT department, 708 8th Street, Armour, SD 57313

Signature of participant, parent or guardian (if under 18)_____ Date: _____

HEALTH QUESTIONAIRE

School: _____ **Sport/Interest:** _____

Height: _____ **Weight:** _____ **Birthdate:** _____ **Allergies:** _____ **EpiPen** Y N

Healthcare Provider & phone #:_____ Date of last sport physical? _____

Have you ever been diagnosed with any of the following?

_____ Coronary Heart Disease	_____ Heart Disease	_____ Rheumatic Heart Disease
_____ Stroke	_____ Congenital Heart Disease	_____ Epilepsy
_____ Heart Murmurs	_____ Diabetes	_____ Hypertension
_____ Cancer	_____ Seizures	_____ Angina

_____ Other, please explain: _____

Do you have any of the following?

_____ Back Pain _____ Joint, tendon, or muscular pain _____ Lung Disease (asthma, emphysema, other)

Please explain: _____

Have you ever experienced chest pain due to physical activity?	Yes	No
Have you experiences chest pain within the last month?	Yes	No
Have you lost consciousness or fallen due to dizziness?	Yes	No
History of concussion?	Yes	No
Any injuries with the last year?	Yes	No

Please explain: _____

Are you under doctor's supervision for any illness or physical condition that may affect your ability to exercise? Yes No

Please list any medications you take on a regular basis: _____

I hereby consent to having my child participate in Douglas County Memorial Hospital's Athletic Performance Training program. I understand that there are risks involved in such participation and relinquish DCMH and Armour School District from all liability. If my child has a pre-existing injury or medical condition, a written clearance from our Physician is required before my child can participate. I hereby allow DMCH to video and/or take photos of my athlete for performance analysis.

Parent's or Guardian's Signature (if under 18): _____

Home Phone: _____ Work Phone: _____

Athlete's Signature: _____