DEGREES TRUST
180

Medical Form

Please complete all sections

Details

Name	
Address	
Mobile	
Email	

Male		Female		Age	

Emergency Contact Details

Contact 1		Number	
Relationship			
Contact 2		Number	
Relationship			
Doctors Name		Number	

Please tick the box if you currently have or have ever had a history of:

Respiratory problems, including Asthma		Orthopedic Problems - bone, joint, ligament, tendons	
Back Pain or Problems		Arthritis, Bursitis or Tendonitis	
High Blood Pressure		Eating Disorders	
Allergies		Injuries or Surgeries	
Seizures		Diabetes	
Congenital disease		Anemia	
Genetic Disease		Fainting spells/Dizziness	

Please describe in detail any items that you checked above

Do you currently or have you ever smoked?

YES		NO		If YES - When	

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Are there any disabilities, special needs or diagnoses we need to know about?

Are you currently on any medication e.g antibiotics/inhaler etc? How frequently do you take it?

Are there any other on-going medical conditions we need to be aware of?

Any special dietary needs?

How would you rate your level of fitness?

Beginner		Intermediate		Advanced	

Signed by Parent or Caregiver ☐

Print Name		Signature	