MEDICAL HISTORY

Student's/Actor's/Participant's Full Name_____

Please read carefully and list the following:

Injury	Date of Injury	Treatment	Place of Treatment

Please list any allergies, including medications:

Please list any chronic physical conditions: i.e. asthma, epilepsy, scoliosis, hypertension, diabetes, tendonitis.....

Please list any emergency contact names and number:

The above information is true, and to the best of my knowledge.

Parent/Guardian Signature_____

Date_____