Team Leadership Center, Inc.
Participant Health Form

The information that is being requested will provide you with the proper care while at the Team Leadership Center.

All information will remain confidential

Name ______________________________ Date of Birth __________________

Group Name ________________________ Program Date __________________

Address ____________________________ Phone ________________________

City _________________________ State ______ Zip __________________________

Email ____

Physician ___________________________ Phone ________________________

In case of emergency, notify _______________ Phone ________________________

Allergies ___________________________ _____________________________

___________________________ _____________________________

Height __________________________ Weight _______________________

Medications currently taken ____

Date of most recent tetanus booster _____ / _____ / _____

Do you currently have any of the following medical conditions? Check if yes√

Pregnancy _________ Heart Condition _________ Diabetes _________

Asthma _________ Current Sprains _________ Current Breaks _________

Other ____

Explain briefly any conditions that are checked (except pregnancy):

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Any other medical conditions which may affect your participation in any physical activity?

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Your signature indicates that the information provided is accurate and current.

_____________________________________ _____________________

Signature (under 18 yrs. of age – Guardian) Date