

HEALTH FORM

TENNIS PLAYER'S NAME _____

This information is confidential to the Director of Recreation unless needed for medical reference.

| Health History | YES | NO |
|--|-----|-----|
| 1. Is the Tennis player allergic to: | | |
| Bee stings | ___ | ___ |
| Insect Bites | ___ | ___ |
| Penicillin | ___ | ___ |
| Aspirin | ___ | ___ |
| Poison Ivy | ___ | ___ |
| Particular Foods: List _____ | | |
| Other Medication: List _____ | | |
| 2. Has participant had/or is subject to: | | |
| Epilepsy | ___ | ___ |
| Heart Trouble | ___ | ___ |
| Convulsions | ___ | ___ |
| Fainting Spells | ___ | ___ |
| Asthma/Wheezing | ___ | ___ |
| Frequent Stomach Upsets | ___ | ___ |
| Serious Illness: List _____ | | |
| 3. Is the participant under medical care for any illness? | ___ | ___ |
| What medication (if any) is the participant NOW taking? _____ | | |
| 4. Has the participant been immunized against? | | |
| M.M.R.(measles,mumps,rubella) | ___ | ___ |
| D.P.T.(diphtheria,pertussis,tetanus) | ___ | ___ |
| Polio | ___ | ___ |
| Date of last Tetanus Booster _____ | | |
| 5. Does the participant wear eyeglasses? | ___ | ___ |
| 6. Should the participant's activities be restricted in any way? | | |
| _____ | | |
| Name of Participant's Doctor _____ | | |
| Doctor's Phone # _____ | | |
| Hospital Preference _____ | | |