

BlazeSports America
Athlete Pre Participation Health Form

Date: _____ Blaze ID#: _____
Name: _____ Date of Birth: _____
Address: _____ Gender: Female Male
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Team Affiliation: _____ Social Security No.: _____
Insurance Company _____ Policy Number: _____

Emergency Contact:
Name & Relationship _____
Phone: _____
Primary Disability: Cerebral Palsy Traumatic Brain Injury Stroke Other: _____
Cause: Congenital (Present at Birth) Acquired
If acquired, please complete the following:

Date of Onset: _____
 Encephalitis/Meningitis/Infection Gun Shot Drug/Poisoning Near Drowning
 Motor Vehicle Accident Other: _____

Disability Related Problems: (Check all that apply)
 Hearing Impairment Learning Disability Perceptual Motor Problems
 Visual Impairment Speech & Language Involvement

List All Past Surgeries (Procedure & Date): _____

List Any Significant Injuries With Date of Occurrence: _____

Medications You Are Currently Taking (Prescription & Over the counter): _____

Medical History:

Date of Last Tetanus Shot: _____
High Blood Pressure No Yes Heart Disease No Yes
Asthma/Lung Disease No Yes Bladder Problems No Yes
Seizures No Yes Type: _____
in past 12 months/Date of last seizure: _____

Diabetes No Yes If yes, are you insulin dependent? _____

Allergies No Yes Explain: _____

Above Conditions Affecting Sports Participation No Yes Explain: _____
Other No Yes Explain: _____

Blaze Sports Classification: Track Field Swimming Indoor W/C Soccer
For the purpose of competitive participation in the following sports: (check all that apply):
 Archery Basketball Boccia Bowling Cross Country Cycling Equestrian Field
 Powerlifting Slalom Soccer Swimming Table Tennis Target Shooting Indoor W/C Soccer
 Track

Permission is given to Blaze, its representatives, a representative of the local team, or competition organizing committee to seek medical care in case of an emergency for the above named person.

Signature of participant or Parent/Guardian if person under 18 years of age Date

BlazeSports America
Athlete Pre Participation Health Form Continued

TO BE COMPLETED BY A LICENSED PHYSICIAN

Athlete's Name: _____

Diagnosis: (List All) _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____ Gender _____

Physical Exam:

	Normal	Abnormal	Explanation of Abnormality
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

Orthopedic Exam:

ROM Loss/Contractures _____

Joints Laxity/Instability _____

Other _____

Significant "**Abnormal Tests**": EKG/X-Ray _____

Approval For Participation: _____ Yes _____ No

Comments/Restrictions: _____

Referral for further evaluations: _____

Physician's Signature _____ Date: _____

Print Physician's Name _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____