
KINGS COUNTY LACROSSE ASSOCIATION

Medical History Form

Name: _____ Birthdate: (D/M/Y) _____

Address: _____

Medicare #: _____ Phone Number: _____

Parent/Guardian Names: _____

Address (if different from above): _____

Home Phone: _____ Work: _____ Cell: _____

Contact person (if parent unavailable): _____ Phone :_____

Family Physician: _____ Phone: _____

Record of Illness – Please state illnesses or conditions, past or present, which may be affected by physical activity:

___ Asthma ____ Diabetes ____ Heart Disease ____ Seizures

Other: _____

_____

Please list any other problems, previous injuries or surgery:

___ Headaches ____ Blackouts _____ Chest Pain _____Fractures _____ Concussion

Other: _____

Does your child wear corrective lenses: ____Y ____ N

Immunization: Year of last tetanus shot _____

Please list all allergies and/or medications taken regularly: _____

_____

_____

Date completed: _____ Signature of Parent or Guardian: _____