All in One Athletics and Recreation
Virginia Beach, VA 23455
www.AIOathletics.com
Medical Release Form

Name_____ Age _____ Birth date_____

Address_____ Phone_____

All questions must be answered. Failure to disclose pertinent medical information may invalidate your insurance coverage and may cancel your eligibility to participate in the "AIO" program.

Medical History:
Have your son/daughter had any of the following? If "Yes", give details on this appropriate form.

	No	**Yes**	**Details (If answered yes)**
Head injury or concussion	____	_____	_____
Bone or joint disorders, fractures, dislocations, trick joints, arthritis or back pain	____	_____	_____
Eye or ear problems (disease or surgery)	____	_____	_____
Heat illness	____	_____	_____
Dizzy spells, fainting, or convulsions	____	_____	_____
Tuberculosis, asthma, or bronchitis	____	_____	_____
Heart trouble or rheumatic fever	____	_____	_____
High or Low blood pressure	____	_____	_____
Anemia, leukemia, or bleeding disorder	____	_____	_____
Diabetes, hepatitis, or jaundice	____	_____	_____
Ulcers, other stomach trouble, or colitis	____	_____	_____
Kidney or bladder problems	____	_____	_____
Hernia (rupture)	____	_____	_____
Mental Illness or nervous breakdown	____	_____	_____

Addiction to drugs or alcohol	____	_____	_____
Surgery or advised to have surgery	____	_____	_____
Taking medication regularly	____	_____	_____
Allergy or skin problems	____	_____	_____
Menstrual problems: LMP	____	_____	_____

Any other important health related issues to add not mentioned above: _____

Emergency Information Card:

Participant's Name: _____ Age _____

Address_____ Home Phone_____

Cell Phone_____ **List two people to contact in case of emergency:**

Parent/Guardian's name_____ Home Phone_____

Address_____ Cell/Work Phone_____

Second Person's Name: Parent/Guardian_____ Home Phone_____

Address_____ Cell/Work Phone_____

Insurance co._____ Policy no._____

Physician's name_____ Phone_____

Are you allergic to any drugs? _____ If so, what? _____

Do you have any allergies (e.g., bee stings or dust)? _____

Do you have _____ asthma, _____ diabetes, or _____ epilepsy? (check any that apply)

Do you take any medications? _____If so, what?_____

Do you wear contacts lenses? _____

Parent/Guardian Signature_____ Date_____

Participant Signature _____ Date_____