[NAME OF ATHLETIC / FITNESS FACILITY]

MEDICAL EMERGENCY ASSESSMENT FORM

All participants over the age of _____, or who have a known medical condition must complete this form before participating in any exercise / fitness or athletic activity at [Name of Facility]. All information will be kept strictly confidential. [Name of Facility] respects the privacy of our participants. The information requested is intended solely for instructor assessment and emergency use only.

Personal Information:

Participant's Name:	
Address:	
Phone Number:	
Medical Insurance / Medicare Card number:	

Physician Information:

Name of Physician:	
Address:	
Phone Number:	

Emergency Contact Information:

Name of Contact:	
Relationship to Participant:	
Address:	
Phone Number:	

DO NOT COMPLETE THIS SECTION.
For Use by Facility Staff Only:

Evaluate participant's overall physical condition *(circle one)*:	Below Average	Average	Above Average	Excellent	
Evaluate participant's [illegible] ability *(circle one)*:	Below Average	Average	Above Average	Excellent	

Medical History:
Do you suffer from, or have you ever suffered from, any of the following conditions? If you answer yes to any of these questions, please provide details in the space provided.

Condition	Yes	No	Details
Allergies	Yes	No	
Asthma or other respiratory disease	Yes	No	
Heart disease	Yes	No	

THIS IS A 2-PAGE FORM.