REBOUNDERS TEAM MEMBER MEDICAL FORM
Due by the first day of fall practice
SECTION A – To be filled out by parent before Physical Exam

I. GYMNAST'S NAME_____
(Last) (First) (Middle)

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____CELL PHONE_____

AGE_____BIRTH DATE_____HEIGHT_____WEIGHT_____

II. Check if your child has had any of the following illnesses:

____Chicken pox	____Diabetes	____Tonsillitis	____Headaches
____German measles	____Epilepsy	____Ear infections	____Hay Fever
____Measles	____Tuberculosis	____Scarlet Fever	____Asthma
____Mumps	____Pneumonia	____Kidney trouble	____Ear aches

III. IMMUNIZATIONS

____DPT Vaccine Latest booster date_____
____Polio Vaccine Latest booster date_____
____Measles Vaccine Latest booster date_____
____German Measles Latest booster date_____

IV. OPERATIONS AND/OR BROKEN BONES (type and date):
_____

SECTION B - To be completed in full by examining Physician

MEDICAL EXAMINATION DATE: _____
GENERAL HEALTH, VITALITY, & ENDURANCE_____
PHYSICAL DISABILITIES_____
ALLERGIES:_____ALLERGY TO PENICILLIN: yes___ no___

Please indicate any medications to be taken by gymnast for any of the above or other conditions:

On the basis of my examination, it is my belief that the subject can participate in all of the activities associated within the field of gymnastics with the following exceptions:
_____

PHYSICIAN'S SIGNATURE: _____DATE_____

ADDRESS_____PHONE_____