PEAK PERFORMANCE
FURMAN UNIVERSITY
CONFIDENTIAL PARTICIPANT HEALTH INFORMATION

Name:_____ Date:_____

Address:_____
Street City/State Zip

Emergency Contact : _____ Home Phone:_____
Work Phone:_____

Insurance Information: I carry medical insurance? Yes____ No____
Name of Provider:_____ Group Number_____

Please complete the following information:

Yes	**No**	
___	___	Are you under treatment for any illness or condition? If yes, please describe:_____
___	___	Do you have any disabilities?
___	___	Do you have a history of respiratory problems? If yes, do you carry an inhaler? _____
___	___	Do you have any allergies? Please list:_____
___	___	Are you allergic to insect bites or bee stings? If yes, do you carry an epipen? Yes___ No ___
___	___	Do you have any back problems? Please describe:_____
___	___	Have you had any dislocation or broken bones? If yes, please explain (include year)_____
___	___	Has your doctor told you to limit your activity in any way? Please explain:_____
___	___	Are you pregnant?
___	___	Are there any **other factors** we should know? Please explain:_____

YOUR SIGNATURE (Parent or Guardian please sign if under 18) DATE