Medical Release Form

Your Information

Name		Date of Birth	
Address			
Phone		Email	

Emergency Contact Information

Primary Contact Name		Relationship	
Phone			
Notes			
Secondary Contact Name		Relationship	
Phone			
Notes			

Do you have a primary care physician?	
Physician Name	

Medical Information

Do you have a history of any of the following?

☐ Diabetes ☐ Asthma ☐ Heart Disease ☐ Epilepsy or Seizure

☐ Allergies Details:

Do you have any weakness, pain, or limited movement in any of your joints or bones? If yes, please describe.

Have you ever had any injury to bones, tendons, or ligaments? If yes, please describe.

Do you have any other medical conditions that might affect your training? If yes, please describe.

Please let your instructor know if you are or begin taking any medications that could affect alertness, cardiovascular capacity, vision, balance, or anything else related to your training.

I hereby certify that the above form describes my physical condition to the fullest extent possible.

Print Name Today's Date

I understand that this form does not in any way limit or invalidate the indemnify and hold harmless agreement I have signed.

Signature: _____

Parental Signature (if under 18 years old): _____