

PHYSICAL EXAMINATION AND MEDICAL HISTORY FORM

1. Does participant have any pre-existing medical conditions? _____

If yes, what are they? _____

2. Do you have any other significant health problems? _____

3. Does participant take any prescription or non-prescription medications? _____

If yes, what are they and what are they for? _____

4. Does participant have any allergies? _____

If yes, what are they? _____

5. Describe participant's current activity and fitness level. _____

Signature _____ Date _____

Print Name _____

Address _____

Phone _____

I have reviewed the information above, reviewed his/her medical history and make the following recommendations for his/her participation in athletics associated with the circus arts; included participation in aerial type activities.

_____ Full Participation _____ Limited Participation

_____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & recommendations:

Physician Signature _____, M.D. Date _____

Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

Physician Name (print) _____

Address _____

City/Zip Code _____

Telephone Number _____