

ORLANDO HOOPS MEDICAL RELEASE FORM

Last Name _____ First Name _____

City _____ State _____ Zip _____ School _____

Height: ___ feet ___ inches Weight: _____ pounds DOB: _____ Grade _____ Age _____

Parent/Guardian's Full Name (s) _____

Home Tel. # _____ Work Tel. # _____ Mobile # _____

1. Does the applicant have a history of any of the conditions listed below:
If so, please circle the condition that applies.

Heart Disease || Cholesterol Level over 260 || Hernia || Rheumatic Disease
Diagnosed Hypoglycemia || Cancer || Chest Pain || High Blood Pressure
Arthritis || Heart Attack || Heart Murmurs || Lung Disease (Asthma, emphysema)
Stroke or Fainting || Frequent Light Headedness || Frequent or sever back pain
Epilepsy/Seizure Disorder || Joint, Tendon or Muscle Pain || Severe shortness of breath
Diabetes || Irregular Heartbeat || Bulimia/Anorexia

Please explain any condition that you circled:

Does the applicant have a history of any other conditions that are not listed above?

____ YES or ____ NO Explain: _____

2. Please list and explain any medical conditions, including surgery, for which a physician has ever recommended restrictions on activity:

3. Please list any medications that the applicant is taking on a regular basis and the reason for taking:

I completely understand that DISHONESTY concerning the issues above could negatively affect the health and welfare of my child. I have been completely honest and hereby, take full responsibility of any problems that may arise from any unknown conditions that my child may exhibit during and after his/her training program.

* In order to provide you with a safe and effective exercise program, the information on this form must be true to the best of your knowledge. If this disclosure form accurately reflects the health history and all medical limitations that may affect your child during his/her work-outs, please sign below:

Parent/Guardian Signature _____ Date _____