

HILLSDALE DANCE ASSOCIATION

MEDICAL FORM: MUST BE COMPLETED BY PHYSICIAN

CHILD'S NAME: _____

ADDRESS: _____

Please indicate any of the following conditions that may affect the child's participation in competitive athletic dance; please explain on the back of this page (age of diagnosis, current medications, etc.) – **CIRCLE YES OR NO:**

- | | | |
|--|-----|----|
| a. Any chronic or recurring illness | YES | NO |
| b. Coughing blood | YES | NO |
| c. Concussion | YES | NO |
| d. Recurring headaches/fainting spells | YES | NO |
| e. Seizures | YES | NO |
| f. Blurred vision | YES | NO |
| g. Recurring nosebleeds | YES | NO |
| h. Heart disease, murmurs and palpitations | YES | NO |
| i. Asthma | YES | NO |
| j. Chest pain during exercise | YES | NO |
| k. Chronic cough | YES | NO |
| l. Heat exhaustion/heat stroke | YES | NO |
| m. Allergies | YES | NO |
| n. Other conditions (specify on back) | YES | NO |

Any other current medication(s):

Orthopedic history: indicate injury/problem, date of injury, age at that time:

DATE EXAMINED: _____

The above child has been examined by me and has been found to be physically fit to participate in the sport of competitive athletic dance.

PHYSICIAN'S SIGNATURE

PHYSICIAN NAME, ADDRESS, PHONE NUMBER:
