

**ARCHDIOCESE OF BOSTON
CYO ATHLETICS
HEALTH FORM**

Name of Participant _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

Male _____ Female _____

Statement of Family Physician Or Clinic:

Is the above participant in general good health and able to participate in the competitive activities of an Ultimate Frisbee league?

Yes _____

No _____ If not, please indicate the limitations on the opposite side.

Immunization History

DPT _____

DPT Booster _____

Tetanus Booster _____

Are there other medical conditions of which the adult monitor should be aware during the course of the season (e.g., convulsions, asthma, allergies, diabetes, injuries, operations)?

No _____

Yes _____ If yes, please specify in detail on the opposite side.

Is the participant taking any medication?

No _____

Yes _____ If yes, please list the medications on the opposite side.

Family Physician or Clinic:

—

