Participant Information

1. Name: _____

2. Address: _____

3. City: _____ State: _____ Zip: _____

4. Home Phone: _____ Business Phone: _____

5. Person to notify in case of accident or emergency:

   Name: _____ Phone #: _____

6. Do you have health/accident insurance? Yes _____ No _____
   If Yes, name of company: _____
   Insurance Company address: _____
   Policy or Certificate number: _____

7. do you have any conditions that would limit your involvement in physical activities?
   (If yes, please explain) _____
_____

8. Are you currently under a physician's care? (if yes, please explain) _____
_____

9. Are you currently taking any medications, prescribed or otherwise? (if yes, please state what you are taking and what condition it is for.) _____
_____

10. Do you have any allergies, reactions to medications, or any other medical limitations?
    (If yes, Identify and explain) _____
_____

11. Do you take any medication for bee stings or other allergies? _____ (if yes bring it w/you)

12. Do you have heart murmurs, episodes of irregular heartbeat, shortness of breath or chest pain or exertion? (if so describe symptoms and physician's diagnosis) _____
_____

13. Do you have asthma? If so has the condition been stable for the past year? _____
_____

14. Do you have problems with your neck, back, arms, ankles, or knees that limit your activities?
    (Describe symptoms and limitations) _____
_____

15. Do you suffer from severe headaches, dizziness, or fainting? (Describe) _____
_____

16. For Females only: Are you pregnant? _____