

Keene State College
Recreational Sports – Sports Club Program
Health Information Form

Sport Club: _____ **Date:** _____

Last Name: _____ **First Name:** _____

Student ID: _____ **Date of Birth:** _____

KSC or Local Address: _____

Local or Cell Phone: _____ **Permanent Phone:** _____

Permanent Home Address: _____
(Street)

_____ (City) _____ (State) _____ (Zip Code)

Parent or Guardian's Name & Address or Other person to contact in an Emergency:

Last Name: _____ **First Name:** _____

Relationship: _____

Address: _____
(Street) _____ (City) _____ (State) _____ (Zip Code)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Health Insurance Information

Insurance Co.: _____ **Phone:** _____

Policy Holder: _____ **Policy Number:** _____

Employer: _____

Important note to all participants!!

Health insurance is very important for you to have in the event that you are sick or injured and need to be treated at a Clinic or Hospital. While Keene State College recommends all students have health insurance, **Recreational Sports requires all club participants to have health insurance.** You are responsible for your own medical health insurance either under your parent's plan or your own.

(OVER)

MEDICAL HISTORY

Circle Yes or No

HEAD:

Have you ever been hospitalized or examined by a doctor for a head injury? **Yes No**

If yes, please explain: _____

Do you wear glasses? **Yes No** Contact lenses (specify hard or soft)? **H S**

Have you ever had any extensive dental work or lost any teeth in an athletic related trauma?

Yes No If yes, please explain: _____

SHOULDER:

Have you had any shoulder injuries? **Yes No** If yes, please explain: R L _____

KNEE:

Have you had any knee injuries? **Yes No** If yes, please explain: R L _____

Did the injury require surgery? **Yes No** If yes, when was the surgery? _____

ANKLE:

Have you had any ankle injuries? **Yes No** If yes, please explain: R L _____

Did the injury require surgery? **Yes No** If yes, when was the surgery? _____

Other:

Are you subject to muscle strains or sprains? **Yes No**

If yes, please specify muscle groups/body parts: _____

Do you have any allergies? **Yes No** If yes, please specify: _____

Are you on regular medication? **Yes No** If yes, please specify medication: _____

Please list any other injuries or medical problems, which have resulted in loss of practice/game time or require special precautions (e.g., inhaler for asthma, etc.):

Signature: _____ Date: _____