Pre-Participation Screening Document

Full Name:

Date of Birth:

Contact Number:

Email Address:

Medical History

- [ ] Asthma
- [ ] Allergies
- [ ] Diabetes
- [ ] Heart Conditions
- [ ] Other

If other, please explain:

Are you currently taking any medication?

( ) Yes ( ) No

If yes, please specify:

Do you have any physical limitations or injuries?

( ) Yes ( ) No

If yes, please specify:

- [ ] I confirm that the above information is true and complete.

Submit