

Minnesota MILE

Record of Medical History

FOR ALUMNI

(please type or print legibly)

Dear Participant:

For our records, and for your protection, please complete this form in it's entirety. Please provide ALL requested information and obtain the signature of your parent or legal guardian.

PERSONAL INFORMATION

(last name)	(first name)	(middle initial)
gender ()	date of birth	place of birth
area code	telephone number	high school / institution you represent
your permanent street address		
city	state	zip code

EMERGENCY CONTACT INFORMATION

(last name)	(first name)	relationship to student / participant
(area code) primary telephone number	(area code) secondary telephone number	
name of family physician	(area code) physisican telephone number	

PERSONAL MEDICAL HISTORY

Please check the following diseases you had in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> German Measles | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> OTHER: _____ | | |

Please check the following conditions you have or had in the past:

- | | | |
|--|---|--|
| Asthma <input type="checkbox"/> | Nose Bleed <input type="checkbox"/> | Dizzy Spells <input type="checkbox"/> |
| Ear Infection <input type="checkbox"/> | Hearing Loss <input type="checkbox"/> | Fainting Spells <input type="checkbox"/> |
| Hay Fever <input type="checkbox"/> | Vision Loss <input type="checkbox"/> | Difficulty Sleeping <input type="checkbox"/> |
| Headache <input type="checkbox"/> | Upset stomache <input type="checkbox"/> | |
| Migraine <input type="checkbox"/> | Convulsions <input type="checkbox"/> | |

OTHER: _____

What treatments or medications (if any) do you require for any of the above conditions?

Are there any past hospitalizations or illnesses we should be aware of?

Please list all allergies (insect stings, plants, foods, medicine, etc)

MEDICATION

Please list any medications you have allergic reactions to (penicillin, sulfa drugs, tetanus antioxin, etc):

Please list the name of any medication you are taking, the dosage, and the condition that requires you to take the medication:

Please list any dietary considerations you have:

IMMUNIZATIONS

Please list the type of illness you have received immunizations for:

Type of Illness:	Approximate Date of Immunization:
<input type="checkbox"/> Mumps	
<input type="checkbox"/> Regular Rubeola Measles	
<input type="checkbox"/> Whooping Cough	
<input type="checkbox"/> Influenza / Colds	
<input type="checkbox"/> Typhoid	
<input type="checkbox"/> Diphtheria	
<input type="checkbox"/> Smallpox	
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio Series	
<input type="checkbox"/> Pneumonia	

GENERAL

If there are any limitations on the amount of physical exercise you can engage in, please describe and explain: (use additional sheet of paper if necessary)

Signature of Participant _____

Signature of Parent or Legal Guardian _____

Date: _____