radKIDS

WELLNESS INFORMATION FORM

Full Name: _____

Address: _____

City:_____ State:_____ Zip: _____

Day Phone: _____ Height:_____ Weight: _____

Gender:_____ Age: _____ Date of Birth: _____

In case of Emergency please contact:

Name: _____

Phone: _____

Relationship: _____

Confidential Medical History

1. Date of most recent medical examination _____
2. Do you feel fine, without restriction? Yes_____ No _____

If no, please describe: _____

_____

3. Have you ever been hospitalized or treated for an injury?

Yes _____ No _____

If yes, please describe: _____

_____

4. Have you ever been injured and not received medical attention?

Yes _____ No _____

If yes, please describe: _____

_____

5. Do you have any current medical conditions for which you are currently being treated? Yes _____ No _____

If yes, please describe: _____

_____

6. Are you currently using any prescription drugs?

Yes _____ No _____

If yes, please describe: _____

_____

radKIDS®
9 New Venture Drive
Unit #4
S. Dennis, MA 02660
(508) 760-2080
www.radkids.org
radkids@radkids.org

7. Do you have:

Any known allergies	Yes _____	No _____
Difficulty breathing	Yes _____	No _____
High blood pressure	Yes _____	No _____
Diabetes	Yes _____	No _____

If yes, please describe: _____

_____

8. How frequently do you exercise? _____

What type of exercise? _____

_____

9. Are you or have you ever been involved in self-defense or Martial Arts Training? Yes _____ No _____

If yes, please describe: _____

_____

10. Please describe your perception of your current fitness level:

_____

_____

The above information is complete, true and accurate to the best of my knowledge.

_____
Signature

_____
Instructors Check

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