MEDICAL INFORMATION & EMERGENCY CONTACT FORM

Torque X Training LLC

Program Name: Torque X Training

Location(s): _____

Phone/Email: _____

Participant Information

Athlete Name: _____

Date of Birth: _____

Age: _____

Phone Number: _____

Email: _____

If participant is under 18 years of age

Parent or Guardian Name: _____

Relationship: _____

Phone Number: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship: _____

Primary Phone: _____

Alternate Phone: _____

Medical Information

Please list any current or past medical conditions, injuries, allergies, medications, or limitations that Torque X Training staff should be aware of.

_____

_____

_____

Physician Name (optional): _____

Physician Phone (optional): _____

Medical Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that it is my responsibility to update Torque X Training of any changes to this information.

Participant Signature: _____

Date: _____

Parent or Guardian Signature (if minor): _____

Date: _____