

## **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: \_\_\_\_\_

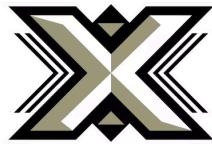
### **Emergency Contact Information**

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.

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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: \_\_\_\_\_