DAYSPRING CHRISTIAN ACADEMY ATHLETE HEALTH HISTORY					
NAME:					
LAST NAME			FIRST NAME		MI
	/ /		MALE	FEMALE	
AGE	D.O.B		GENDER		
					( ) -
HOME MAILING ADDRESS	CITY	STATE	ZIP CODE		HOME PHONE #
			( ) -		
EMERGENCY CONTACT	RELATIONSHIP		EMERGENCY CONTACT #		
PCP NAME		PCP CONTACT #			
MEDICATION(S):					
ALLERGIES				LATEX ALLERGY: Y/N	
RELEVANT MEDICAL HISTORY(seizure, diabetes, etc):					
HISTORY OF CONCUSSIONS:	Y/N IF YES EXPLAIN:				
PARENT/GUARDIAN SIGNATURE:	-		DATE:	/ /	