



MEDICAL REPORT FORM (FORM #2)

Student Name : _____

No Student will be allowed to participate or be enrolled to NAF without completion of all medical forms required by NAF. Please complete every question on this form so that NAF may be informed as to all health conditions, medications, and medication requirements during your child's enrollment at NAF. Please note all medication and medication requirements for the Student shall be submitted with the Enrollment Application and this Medical Form. Upon admittance at NAF all medication brought by the Student shall be sealed with Student's name and identification number and shall be kept in a pharmacy container.

PARTICIPATION IN THE NATIONAL ACADEMY OF FITNESS (NAF) PROGRAMS SHOULD NOT BE CONSIDERED IF ANY OF THE FOLLOWING CONDITIONS EXIST:

- X EXTREME OBESITY
- X RENAL DISEASE
- X CHRONIC TRANQUILIZER USE
- X DIABETES OR HYPOGLYCEMIA
- X ARTHRITIS
- X PREGNANCY

MEDICAL INFORMATION SUMMARY

Patient's Name: _____

Date of Birth: _____

MEDICATIONS AND ALLERGIES?	YES	NO	PRESENT CONDITION OR MEDICATION AND DOSE
1. Is your child currently on any prescribed medications?			
2. Has your child previously been on prescribed medications?			
3. Does your child have any specific allergies to foods, drugs, or other substances?			

DOES YOUR CHILD HAVE OR HAS HE/SHE EXPERIENCED ANY OF THE FOLLOWING DURING THE PAST YEAR?

HAS YOUR CHILD EXPERIENCED:	YES	NO	PRESENT CONDITION OR MEDICATION
4. Ear pain or any problem with hearing?			
5. Eye discomfort or other difficulties?			
6. Frequent or migraine headaches?			
7. Dizziness or fainting spells?			
8. Hay fever or nasal problems?			
9. Hives or skin allergies?			
10. Skin sores or rashes?			
11. Warts or sores on feet?			
12. A lump, mole, or swelling?			
13. Chest pain or shortness of breath?			
14. Coughing?			
15. Sweating at night?			
16. Spitting or coughing up blood?			
17. Urinary burning, frequent urination, or dark urine?			
18. Stomach aches, burning, or indigestion?			
19. Difficulty starting urination, or dribbling?			
20. Difficulty walking, running, or lifting things?			
21. Pain in back, neck, or joints?			
22. Excessive weight gain?			
23. Unexplained weight loss?			
24. A rupture or hernia?			
25. Diarrhea or unusual bowel movements?			
HAS YOUR CHILD EXPERIENCED:	YES	NO	PRESENT CONDITION OR MEDICATION
26. Any injury or illness?			

27. High blood pressure?			
28. Excess bleeding?			
29. STD?			
30. Tumor, growth, cyst or cancer?			
31. A knee or ankle injury?			
32. Arthritis or swollen and painful joints?			
33. Does your child currently wear glasses?			
34. Nervous breakdown?			
35. Appendicitis?			
36. Frequent colds?			
37. Ear pain or hearing loss?			
38. Eye discomfort or sight loss?			
39. Surgery?			

HAS YOUR CHILD EVER HAD:	YES	NO	PRESENT CONDITION OR MEDICATION
37. Rheumatism?			
38. Kidney disorders?			
39. Ear infection?			
40. Pneumonia?			
41. Scarlet fever?			
42. Long measles or 3 day measles?			
43. Typhoid?			
44. Chicken pox?			
45. Polio?			
46. Chronic tranquilizer user?			
47. Hypoglycemia'?			
48. Obesity?			
49. Renal disease?			
50. Anemia?			
51. Mumps?			
52. Rheumatic fever?			
53. Birthmarks and/or tattoos?			
54. Seizures, convulsions, or epilepsy'?			
55. An ulcer?			
56. Asthma or wheezing?			
57. A back injury or deformity?			
58. Heart trouble or disease?			
59. Diabetes or sugar in the urine?			
60. Goiter or other thyroid problems?			
61. Special dietary needs?			
62. Orthopedic appliances, including braces?			

IMMUNIZATIONS:	DATE
Diphtheria, Tetanus, & Pertussis (whooping cough,DTP)	
Diphtheria--Tetanus (DT)	
Tetanus Toxoid	
Measles, Mumps, & Rubella (MMR)	

FEMALES ONLY:	YES	NO	PRESENT CONDITION OR MEDICATION
1. Vaginal discharge?			
FEMALES ONLY:	YES	NO	PRESENT CONDITION OR MEDICATION
2. Pregnancy?			

3. Painful menstruation?			
4. Spotting between periods?			
5. Flowing longer than 8 days?			
6. Excessive sore or tender breasts?			

If you have answered "YES" to any of the proceeding questions, then please provide any additional comments or supplemental responses you deem necessary for applicant's consideration: _____

Please identify all hospitalization and surgery the Student has had: _____

SPORTS: Are there any known physical conditions that would preclude your child from participating in sports or physical education classes? Yes No If yes, please explain: _____

DENTAL BRACES: Does your child have braces and/or a retainer? Yes No
 If yes, do you wish, at your expense, to have regular check ups by a local Orthodontist? Yes No
 Name of Orthodontist: _____ Appointment date: _____

Please provide the following information:

Primary Care Physician: _____ Phone Number: _____
 Psychiatrist: _____ Phone Number: _____
 Dentist or Orthodontist: _____ Phone number: _____
 Optometrist: _____ Phone number: _____

The Undersigned hereby certify that the above is a complete and honest report of Student's personal health history. No personal health information has been withheld or misrepresented. The Undersigned hereby understand that the information above may be used by NAF to determine eligibility for NAF programs, or may be provided to other physicians or care providers in the event care becomes necessary or appropriate.

Dated this ____ **day of** _____, **20**____ .

Father/Guardian

Mother/Guardian

Student