Form completed by: _____

Please answer **all** questions by circling "YES" or "NO". Explain "YES" answers in the area below.

1.	Have you had any medical problem or injury since your last physical?	YES	NO
2.	Have you ever been hospitalized?	YES	NO
3.	Have you ever had surgery?	YES	NO
4.	Do you use nicotine products? (vaping, cigarettes, chewing tobacco, etc.)	YES	NO
5.	Are you taking any other pills, vitamins, minerals, supplements, herbal treatments, or energy/enhancing drinks/powders/pills/shots/foods?	YES	NO
6.	Have you ever passed out during exercise?	YES	NO
7.	Have you ever had shortness of breath after exercise?	YES	NO
8.	Have you ever had chest pain during or after exercise?	YES	NO
9.	Have you ever been dizzy during a workout?	YES	NO
10.	Do you have high or low blood pressure?	YES	NO
11.	Do you have any skin problems (itching, rashes, acne)?	YES	NO
12.	Have you ever had a head injury, concussion, or been knocked out?	YES	NO
13.	Have you ever had a seizure?	YES	NO
14.	Have you ever had a stinger, burner, or pinched nerve?	YES	NO
15.	Have you ever had heat or muscle cramps?	YES	NO
16.	Have you ever had or been diagnosed with a heat related illness?	YES	NO
17.	Have you ever had problems with your vision or eyes?	YES	NO
18.	Do you wear glasses, contacts, or protective eyewear?	YES	NO
19.	Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any body parts? (*Please circle and add notes below)* Head Shoulder Thigh Neck Elbow Knee Chest Forearm Back Shin/Calf Wrist Ankle Hip Hand Finger(s) Abdominal Other	YES	NO
20.	Have you ever had any other medical problems (mononucleosis, diabetes, seizures, asthma, etc.)? Please list:_____	YES	NO
21.	Are you currently under the care of a physician? IF YES Explain here:_____	YES	NO
22.	Have you been prescribed medications? If yes to prescription medications, are you taking them? *Please list prescription(s) here, whether taking or not:* _____ _____ _____	YES YES	NO NO
23.	Have you ever had any mental health concerns? (ADD, ADHD, anxiety, depression, suicidal thoughts, other mood disorders, etc.)	YES	NO
24.	If Female: Do you have menstrual periods? What was the longest time between periods in the past year, and are they regular? Time between_____ Regular?:	YES YES	NO NO
25.	Have you been tested for sickle cell anemia or sickle cell trait? If Yes, have you been diagnosed with sickle cell anemia or sickle cell trait?	YES YES	NO NO

PLEASE EXPLAIN ANY "YES" ANSWERS:

_____

_____

_____

Have you had, or are there any other issues, illnesses, or injuries that have not been addressed above from your career as a performer, marcher, dancer, or instrumentalist? Circle one: YES NO Please explain YES answers:

_____

_____

_____

I consent to an orthopedic screening to be provided by volunteer medical personnel:

Signature_____ Date_____

(if under 17 years of age or younger, a parent or guardian must be present and sign below):

Signature_____ Date_____