**WWU SPORT CLUBS**
**MEDICAL DISCLOSURE FORM**

**TO BE COMPLETED AND SIGNED BY STUDENT BEFORE PARTICIPATING IN PHYSICAL ACTIVITY**

**COMPLETE NAME OF PARTICANT** ____________________________________________________________

**SPORT CLUB** ______________________  **DATE OF BIRTH** ___________________________

**AGE** ______  **SEX**  M □  F □  **MARITAL STATUS**  M □  S □  W □  D □  SEP □

**PAST/CURRENT MEDICAL HISTORY** (check box for any “yes” answers)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recurrent ear infections</th>
<th>Psychiatric consultation/ Treatment/hospitalization</th>
<th>Venereal disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
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<tr>
<td>Dizziness or fainting spells</td>
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<tr>
<td>Paralysis/numbness/tingling</td>
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<tr>
<td>Epilepsy-fits, seizures (convulsions)</td>
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<td>Eye disease-glaucoma, etc.</td>
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<tr>
<td>Wears corrective lenses</td>
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<tr>
<td>Eye surgery to correct vision</td>
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<tr>
<td>Lack of vision in either eye</td>
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<tr>
<td>Chest pain</td>
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<tr>
<td>Heart Trouble</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Shortness of breath</td>
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<tr>
<td>Rheumatic Fever</td>
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</tbody>
</table>

Do you have, or have had:
- Tuberculosis  □
- Diabetes  □
- Cancer  □
- Headaches  □
- Epilepsy  □
- Mental Illness  □
- Heart Trouble  □
- High Blood Pressure  □
- Stroke  □
- Other  □

Please disclose any chronic or serious physical or psychiatric condition that might affect your full-time participation in the program of study. If so, please provide name of condition, duration (specify dates), and final results.

Have you ever been under observation, had medical, psychiatric, or surgical advice or treatment, or have been hospital-confined?
If so, please provide name of condition, duration (specify dates), and final results.

To the best of your knowledge and belief, are you in good physical and mental health?

Additional History/Comments: ________________________________________________________________

Do you have a primary physician? Please provide your physician’s name and telephone number:

________________________________________________________________________________________
## MEDICAL HISTORY

1. **What is your current occupation?** ________________________________________________________________

2. **List any occupational or other hazards to which you have been exposed:** Hobbies: _______________________

3. **Are you being treated for any condition now?** _______________________________________________________

4. **Have you ever been absent from work or school for longer than one month’s illness?** If so, when?
   And for what illness? _____________________________________________________________________________

5. **Have you had any accidents as a result of which you are partially disabled?** If so, what and when?
   Do you have any other disability? Please explain: ______________________________________________________

6. **Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst in the last 5 years?**
   If so, please give his/her name and telephone number: _____________________________________________
   For what reason? __________________ Date of consultation _____________________________

7. **Are you taking any medicine regularly?** If so, what? ______________________________________________

8. **Do you have any allergies?** If so, which? ____________________________________________________________________________

9. **Have you gained or lost weight during the last three years?**
   If so, how much? _____________________________________________________________________________

10. **Have you ever been refused employment on health grounds?**
    If so, please state reason: _____________________________________________________________________

11. **Have you ever stayed in a tropical country?** If so, for how long? _________________________________

12. **Do you smoke?** If so, what do you smoke? Cigarettes ______ Pipe ______ Cigars ______
    For how many years have you smoked? ______ How much per day? ________________________________

13. **Daily consumption of alcoholic beverages:** _____________________________________________________________________________

14. **Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future?**
    Give details _________________________________________________________________________________

15. **Do you exercise?** How often? _____________________________________________________________________________

16. **FOR WOMEN**
    **Have you ever been treated for a gynecological complaint?** YES NO
    If so which and when? _______________________________________________________________________

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**SUMMARY:**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**Physician’s Name (Please Print) __________________________**

**Physician’s Signature __________________________**