

# Skyview Gymnastics

2603 Back Acre Circle, Mount Airy, MD 21771

301 829-7998 fax: 301 829-7996

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## Medical Information Form

The information you provide will be held in strict confidence.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of school that student attends? \_\_\_\_\_

Doctor's Name/Address \_\_\_\_\_ Doctor's. Phone \_\_\_\_\_

Date of last tetanus immunization \_\_\_\_\_

**\*\*Please attach a list of all immunizations and dates.**

All children must be current on all of the required immunizations for the state of Maryland.

**Allergies** Yes or No (*If yes please list below*)

1. \_\_\_\_\_

2. \_\_\_\_\_

**Medication** Yes or No (*If yes please list below*)

1. \_\_\_\_\_

2. \_\_\_\_\_

**Broken Bones or Other Injuries**

Yes or No (*If yes please list below*)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Has the participant been evaluated for or diagnosed with any type of Learning Disability? Please Describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does the Participant . . . . .**

**Wear contacts?** Yes or No

**Have High Blood Pressure?** Yes or No  
(For Adult Classes)

**Have Asthma?** Yes or No

If yes, does he/she carry an inhaler? Yes or No

Are there any other health, physical or mental conditions that might affect the student's ability to participate in gymnastics classes or activities? Any other information that might be important for us to know in an emergency situation? (i.e. diabetes, history of seizures, blindness in one eye, partially deaf...) If yes, please describe them below in detail.

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I (parent or legal guardian) \_\_\_\_\_ certify that the above information and the attached list of immunizations is accurate and complete. **In the event that any information should change, I will notify Skyview in writing so that the information can be attached to this file.**

\*\*This form will be kept on file for one year. New forms need to be completed each year in the Fall.

**Signature of parent or guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Permission to give Medication**

\_\_\_ I hereby give permission for my child to be given 1 or 2 (please circle) tablets/capsules of regular strength Tylenol (acetaminophen) or Advil (ibuprofen) if he/she requests it.  
(Please indicate if you prefer one or the other.)