GSC-Master Guide
Medical History and Consent for Treatment Form

Name _____ Date _____

Situation	YES	NO	Comments
Had or currently have any heart conditions?			
Frequently suffer from chest pain?			
Often feel fainting or dizzy spells?			
Has a doctor ever told you have high blood pressure?			
Have arthritis, joint pain, or back issues that are aggravated by activity?			
Had any operations or serious injuries?			
Have any physical disabilities or recurring illness?			
Have epilepsy or other seizure disorder?			
Have diabetes?			
Have allergic reactions to food, medications or other? If yes, please list allergies			
Currently sick or using prescribed medications? If yes, please list medications			
Have a prescribed meal plan or dietary restriction? If yes, please list all restrictions			
Are there any activities to be limited/discouraged by a Physician's advice? If yes List the limitations			
Carry health insurance. List Carrier-and Phone Number			
Policy Number			
Group Number			
General Health statement			
Please explain any additional medical information we need to provide for your safety			
Is there anything else we need to know about your health?			
Other			

I _____, confirm that all medical information is true. Date _____

Electronic entry signature date _____