

Youth Dance Theatre of Michigan
 MEDICAL HEALTH FORM (This page to be completed by dancer and parent)

Dancer's Name: _____ Birth Date: _____ Age: _____
 Address: _____ Home Phone: _____
 Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____
 Father's Name: _____ Daytime Phone: _____ Cell Phone: _____

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

MEDICAL INFORMATION

	YES	NO
1. Has any member of your family had a heart attack, heart problem, or died unexpectedly before age 50?		
2. Have you ever passed out or felt dizzy during exercise?		
3. Do you have asthma or allergies?		
4. Have you ever broken a bone, worn a cast, or injured a joint?		
5. Have you ever been knocked out or had a concussion?		
6. Do you have a chronic illness or see a doctor regularly?		
7. Do you take any medications regularly?		
Explain any "YES" answers and/or supply any additional health information of which YDT should be aware:		
For Women Only: a. At what age did you experience your first menstrual period? _____ b. In the last year, what is the longest time you have gone between periods? _____		

Doctor: _____ Address: _____ Phone: _____

Insurance Provider: _____ Policy Holder: _____ SS # or ID #: _____

Employer: _____ Employer Phone: _____ Policy #: _____

In an emergency, I request that measures be instituted without delay as the judgment of medical personnel dictates.

Parent Signature: _____ Date: _____

IF I CAN NOT BE REACHED IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT THE FOLLOWING

Name: _____ Relationship to Dancer: _____

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____

I hereby state that, to the best of my knowledge, the answers to the above questions are correct.

Dancer Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Youth Dance Theatre of Michigan

Date of Exam _____

MEDICAL HEALTH FORM (This page to be completed by physician)

Dancer's Name: _____ Birth Date: _____ Age: _____ Pulse: _____ B/P: _____

Vision: (R) 20/____ (L) 20/____ (B) 20/____ corrected/uncorrected Height: _____ feet _____ inches _____ Weight: _____ lbs

	Normal	Abnormal Findings
Hair, Scalp		
Eyes, Ears, Nose		
Mouth, Teeth, Throat		
Cardiovascular		
Chest, Lungs		
Abdomen		
Genitalia		
Skin		
Musculoskeletal:		
Neck		
Upper Extremities		
Back		
Lower Extremities		

Additional comments or concerns not addressed on this form:

I have examined the person herein described and have reviewed the health history. It is my opinion that this dancer is physically able to engage in strenuous dance activities, except as noted above.

Examining Physician Signature: _____ Date: _____

Telephone number: _____ Address/City/State/Zip: _____

Stamp or printed name of physician: _____