



Liberty Bell Judo

Membership Registration and Application Form

Medical Information

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Insurance information: Company _____ Policy # _____

Name of Insurance holder (if different from above) _____

Name of Family Physician: _____

Physician's Address _____

Phone () _____ Date of Last Physical Examination _____

It is always important to consult your physician before starting an exercise program.

Medical History Questionnaire

Yes No 1. Do you have asthma? What medications do you need to take for the asthma?

Yes No 2. Do you wear contacts or glasses while in athletic practice or competition?

Yes No 3. Do you wear any dental appliance? If yes please list whatever you have.

Yes No 4. Have you had any recent minor injuries (such as a sprain ankle, knee etc.)?

If so please list.

Yes No 5. Have you had any recent, in the last two years, serious injuries to any bones or joints?

If so please list.

Yes No 6. Have you ever had an injury to your back?

Yes No 7. Do you have any heart problems?

Yes No 8. Do you have any other CHRONIC CONDITIONS that have not been mentioned above?

If so please list and explain.

Yes No 9. Do you smoke?