Flips
Student Information & Medical History

Client Information:

Student Name:_____ _____ **Birth-date:**_____ **Age:**_____

Parent/Guardian Name:_____ **Parent/Guardian Name:**_____

Address:_____

City/State/Zip: _____ **Home Phone:**_____

Work Phone: _____ **Cell Phone:**_____

Parent/Guardian's Email:_____ **Student's Email:**_____

Medical History Update

1. Are you currently taking any medications? Yes or No List type and what for: _____

_____

2. Do you have any allergies? Indicate Yes or No next to each category below.

____ **Allergies to medications. List medications:** _____

____ **Food allergies. List foods:** _____

____ **Allergic reaction to bee sting. Note emergency procedure to be followed.** _____

____ **Other allergies. Describe.** _____

3. Do you wear glasses? Yes or No and/or contact lenses? Yes or No

Over the past year have you had any of the following?

4. Chest pain while exercising? Yes or No

5. Fainted or nearly fainted while exercising? Yes or No

6. Unexplained shortness of breath or fatigue with exercise? Yes or No

7. Been knocked out or experienced a concussion? Yes or No When? _____

8. Suffered from heat illness or injury? Yes or No When?_____

9. Suffered an injury requiring medical attention? ? Yes or No If yes, what? _____

_____

_____

_____

11. Had any other injury or illness since your last exam? Yes or No If yes, what? _____

_____

_____

12. Describe any existing medical conditions and any limitations imposed by such conditions.

_____

_____

_____

_____

Student's Primary Care Doctor: _____ Phone _____

Choice of Specialists: _____

Health Insurance Company: _____ Group/Policy # _____

Medical Power of Attorney

From: _____
[*Full Name(s) of Parent(s) or Guardian(s)]*

To: Representative of Flips, LLC, t/a Flips Gymnastics Team

This power of attorney shall be effective during such period of time as we, or either of us, may for any reason not be available to give our consent to any medical diagnosis or treatment, including surgery, for our child. I (We) _____ *[Full name(s) of parent(s)/guardian(s)]* of _____ *[Residential Address in Full]* do hereby appoint Representative of Flips, LLC, t/a Flips Gymnastics Team our true and lawful attorney in fact, with full power in loco parentis, to decide upon and consent to the rendering of any medical diagnosis and treatment, including surgery, which he/she deems in the best interest of the health and welfare of our child, _____ *[Child's Name].*

This power of attorney shall not be affected by the disability of either or both of us, but shall continue in full force and effect during any such disability.

Executed this _____ day of _____, 20__.

_____ _____
Signature of Witness Signature of Parent or Guardian

_____ _____
Signature of Witness Signature of Parent or Guardian