



**MEDICAL HISTORY FORM**

(1) Please give an explanation of any of the following conditions now or in the past:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Down Syndrome            |
| <input type="checkbox"/> Heart Murmur                  | <input type="checkbox"/> Fracture                          | <input type="checkbox"/> Atlantoaxial Instability |
| <input type="checkbox"/> Dental Appliances             | <input type="checkbox"/> Surgery                           | <input type="checkbox"/> Autism                   |
| <input type="checkbox"/> Sight Difficulties            | <input type="checkbox"/> Dislocation or Sprain             | <input type="checkbox"/> Sensory Processing       |
| <input type="checkbox"/> Eye Glasses or Contact Lenses | <input type="checkbox"/> Back or Neck Injury               |   |
| <input type="checkbox"/> Ankle or Foot Problem         | <input type="checkbox"/> Nose Bleeds                       |   |
| <input type="checkbox"/> Elbow or Wrist Problem        | <input type="checkbox"/> Hearing Difficulties              |   |
| <input type="checkbox"/> Foot or Hip Problem           | <input type="checkbox"/> Attention Deficit Syndrome        |   |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Sequence Learning Difficulty      |   |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Allergic Reaction to Insect Bites |   |
| <input type="checkbox"/> Hyperactivity                 | <input type="checkbox"/> Skin Allergies                    |   |
| <input type="checkbox"/> Processing Problem            | <input type="checkbox"/> Learning Disability               |   |

Explanations: \_\_\_\_\_  
\_\_\_\_\_

(2) Explain any conditions not listed above: \_\_\_\_\_  
\_\_\_\_\_

(3) Is the gymnast currently on medication? YES \_\_\_\_\_ NO \_\_\_\_\_  
Type: \_\_\_\_\_  
Purpose: \_\_\_\_\_

(4) Name and Phone Number of Physician: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_

**MEDICAL / HEALTH ACKNOWLEDGEMENT**

I acknowledge that gymnastics is a strenuous, physical sport, and I certify that my child and all parental participants are in good health and physical condition and are fully able to participate in the program.

**X** \_\_\_\_\_  
Parent or Guardian's Signature Date

**ACKNOWLEDGE OF RISK AND WAIVER OF LIABILITY**

I hereby consent to my and/or my child's participation in the programs of Gymnastics, Inc. d/b/a North Raleigh Gymnastics (NRG). I understand that injuries can occur and risk is involved in any athletic activity for myself or my child, especially gymnastics activity that involves height and motion.

I further agree that NRG, along with the employees, agents, officers, and directors of NRG shall not be liable for any losses or damages occurring as a result of my and/or my child's participation in gymnastics, including transportation to and from activities, except where such loss or damage is the result of the intentional or reckless conduct of one of the organizations or individuals identified above.

This acknowledgment of RISK AND WAIVER OF LIABILITY AND MEMBERSHIP AGREEMENT has been read and is signed voluntarily.

**X** \_\_\_\_\_  
Parent or Guardian's Signature Date