



## Confidential Wellness Form

### (Safety and Emergency Purposes Only)

Student Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

In case of emergency contact (we require a parent to attend, but just to be safe)

Name \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

1. Date of most recent medical examination \_\_\_\_\_

2. Do you feel fine? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please describe

\_\_\_\_\_

3. Have you ever been hospitalized or treated for an injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe:

\_\_\_\_\_

4. Have you ever been injured and not received medical attention? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

5. Do you have any medical conditions? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_



6. Are you currently using any prescription drugs? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

7. Do you have:                    Any known Allergies? Yes\_\_\_\_\_ No\_\_\_\_\_

    Difficulty Breathing? Yes\_\_\_\_\_ No\_\_\_\_\_

    High Blood Pressure? Yes\_\_\_\_\_ No\_\_\_\_\_

    Diabetes?                                    Yes\_\_\_\_\_ No\_\_\_\_\_

8. How frequently do you exercise? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

9. Are you now, or have you ever been involved in a self-defense or Martial Arts Training? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe:

\_\_\_\_\_

10. In your own words, please describe your current fitness level.

The above information is complete, true and accurate to the best of my knowledge.

Parent Signature \_\_\_\_\_

Student Signature \_\_\_\_\_

Instructor Review/Date \_\_\_\_\_