

Summit Sports Training Center

Villanova West Chester
WWW.SUMMITSPORTSTC.COM
ATHLETE INFORMATION

Athlete Name _____
Last First Middle
Address _____
Number & Street
City: _____ State _____ Zip _____ Phone _____
E-Mail _____ Date of Birth _____ Gender M / F
School _____ Club _____
List All Sports and Positions _____

Mother's Name _____ E-mail _____
Father's Name _____ E-mail _____
Employer: Father _____ Mother _____
Emergency Contact _____ Phone: _____
Primary Care Physician _____ Phone: _____

How did you learn about Summit? Friend/Family -
Name: _____

Flyer Mailing Sporting Event Coach -
Name: _____

Phone Call from Summit Coach Other -

MEDICAL HISTORY

It is extremely important that you provide accurate and complete information about the athlete's medical background and current physical condition, as the training protocols and procedures recommended will be based on such information. Has the athlete or any immediate family members (Mother, Father, Brothers, Sisters, Grandparents) had any of the following conditions? **Please check all that apply.**

Condition	Ath	Family	Condition	Ath	Family	Condition	Ath	Family
Aneurysm			Diabetes			Hypertension		
Angina			Dizziness			Hypotension		
Arrythmia			Dyspnea			Rheumatic Fever		
Arthritis			Emphysema			Stress Fractures		
Asthma			Fainting			Thrombosis		
Bronchitis			Heart Attack			Tuberculosis		

Please list any injuries or conditions that would limit the athlete's participation in our training program.

Please list any surgeries the athlete has had performed within the last 3 years.

Please list any medications that the athlete is currently taking and the reasons why.

Athlete Signature

Parent Signature

Date