West Haven Parks & Recreation
Medical Permission Form

Personal Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	Blood type	
Address			
City	State	Zip Code	
Phone:	Email:		

Medical History

Has a doctor ever told you that you have (check all that apply):

High blood pressure ☐ Heart murmur ☐
High cholesterol ☐ Heart infection ☐

Do you have any prescriptions for use of epinephrine, adrenaline inhaler, or other allergy medications? If yes: please explain:_____

Have you ever had a seizure?
Y N

Do you have problems with incontinence?
Y N

Participant signature:_____Date:_____

This individual may: ☐ participate fully in the program.
☐ participate in the program with the following restriction/adaptation.

Physician signature:_____Date:_____

Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Secondary Contact Name & Relationship	Secondary Contact Phone Numbers