

MOUNTAIN SHEPHERD

Student Health History Form

Name _____ Height _____ Weight _____

Doctor's Name _____

Doctor's Phone Number _____

Please complete the following regarding medical and health history:

Under treatment for any illness or injury? _____ If yes, please describe.

Currently is taking any form of medication? _____ If yes, please describe.

Have a history of heart problems? _____ If yes, please describe.

Have any past injuries? _____ If yes, please describe.

Please list anything we should be aware of regarding your health.

Date _____

Signature of Participant