Medical Fitness to Compete

This form MUST BE COMPLETED or your Application to compete will NOT be accepted.

Name _____ **Date of Birth** _____ **Phone** _____

Address _____ **AHC#** _____

1. I hereby certify that I have not suffered a concussion, head injury, loss of consciousness or blow to the head followed by dizziness, memory loss or headache **in any activity** in the past 30 days.

   Signed _____

   Under 18 years, Legal Guardian _____

   Date _____

2. Have you suffered a head injury, loss of consciousness, concussion or blow to the head in the past 6 months?

   _____ YES _____ NO

3. If **YES**, what symptoms did you have **after** the injury?

   ___ dizziness ___ blurred vision ___ amnesia ___ feeling in a fog
   ___ tingling ___ headache ___ irritability ___ ringing in the ears
   ___ numbness ___ nausea ___ vomiting ___ sensitivity to light
   ___ inability to concentrate ___ seeing flashing lights

4. Of the above symptoms, do you still experience any of these?

   _____ YES _____ NO