

IHSRA MEDICAL QUESTIONNAIRE

Contestant's Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

Mothers' Name: _____ **Father's Name:** _____

Address: _____ **Address:** _____

Phone #: _____ **Phone #:** _____

Emergency Contact other than Parent/Guardian: _____

Address: _____ **Phone #** _____

Contestant's Medical Information:

Known Allergies: _____

Medical Risks: _____

Current Medications: _____

Primary Physician: _____ **Phone#:** _____

Address: _____

Primary Insurance: _____

Address: _____

Policy Number: _____ **Phone #:** _____

Other information pertinent to the contestant's well being: _____
