

Health Statement

Name of University of Idaho Program Participant:

Please list any and all physical conditions that UI program staff should know which may affect or be affected by participation in this program.

Present medical problems or conditions:

Medications taken regularly:

Allergies (including allergies to medications):

Limitations on physical activities:

Wear contact lenses? Yes _____ No _____

Wear glasses? Yes _____ No _____

Signature of participant

Date

Signature of parent or guardian
(required if participant is less than 18 years of age)

Date