ICSCC 2020 MEDICAL HISTORY APPLICATION

(To be filled out by the Applicant each license application whether or not you require a physical exam by doctor)

Name: _____ Birthdate: _____ Sex: _____

Address: _____

City: _____ State/Prov: _____ Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Occupation: _____

Personal Physician: _____

Physician's Address: _____ Phone: ( ) _____

City: _____ State/Prov: _____ Code: _____

Examining Physician (if applicable): _____

Physician's Address: _____ Phone ( ) _____

City: _____ State/Prov _____ Code _____

DO YOU HAVE A HISTORY OF THE FOLLOWING? (Please Check)

		NO	YES
1.	Frequent or unusual headaches? _____	❑	❑
2.	Fainting spells? _____	❑	❑
3.	Unconsciousness? _____	❑	❑
4.	Eye disorder? _____ Wear glasses? _____	❑	❑
5.	Nervous System disorders? _____	❑	❑
6.	Asthma _____	❑	❑
7.	Allergies _____	❑	❑
8.	Diabetes _____	❑	❑
9.	Heart or circulation disorders? _____	❑	❑
10.	High or Low Blood pressure _____	❑	❑
11.	Anemia or easy bleeding _____	❑	❑
12.	Intestinal disorder? (Stomach, colon, etc.) _____	❑	❑
13.	Kidney stone or tumor _____	❑	❑
14.	Psychiatric problems _____	❑	❑
15.	Treatment for alcoholism or drug habit _____	❑	❑
16.	Attempted suicide _____	❑	❑
17.	Admission to hospital for surgery, or other reason _____	❑	❑
18.	Rejection for life or disability insurance _____	❑	❑
19.	Medical rejection from or for military service _____	❑	❑
20.	Disability compensation for any reason _____	❑	❑

"Please use reverse side for details and list all medications (prescription or over-the counter) being used.

"I certify that my answers are true, complete and accurate.
If there are changes to the above information during the course of the season, that applicant is required to report them to the ICSCC License Registrar and receive clearance before participating in any subsequent events. Omitting or intentionally providing misleading information may result in the revocation of ICSCC license credentials and all privileges pertaining to ICSCC events."

APPLICANT'S SIGNATURE: _____ DATE: _____