

KISHWAUKEE COLLEGE ATHLETE PERSONAL DATA FORM



Last Name _____ First Name _____ Middle Name _____

School Address _____
Street Address City Zip Code

Cell Phone # () _____ Social Security Number _____

Date of Birth ____/____/____ Year in College _____ Sport _____

Emergency Contact Person _____ Relationship: _____
First Name Last Name (Parent/Guardian, Aunt/Uncle, Sibling, Grandparent, Friend)

Emergency Contact Phone Number (s): () _____ () _____

Family Physician _____
Name City State Phone #

List Allergies:

Penicillin	YES	NO
Sulfa Drugs	YES	NO
Other Drugs	YES	NO
Foods	YES	NO
Environment	YES	NO

Explanation:

Do you take medications regularly? YES NO If yes, list and explain.

Do you wear eyeglasses when you participate in sports? YES NO

Do you wear contacts when you participate in sports? YES NO

If you do wear contacts, describe the type. (soft, hard, gas permeable, extended wear) _____

If you answered YES to either of the above, please name the prescribing physician below.

Name City State Phone #

List all dental appliances worn. (retainers, braces, caps, bridges) _____

Kishwaukee College Athletic Trainer Reviewed Signed: _____ Date ____/____/____