



Student-Athlete Information:

Emergency Contact Information:

Name		Name(s)	
NIU ID #		Relationship	
Date of Birth		Address	
Local Address		City, State, Zip	
Email Address		Home Phone #	()
Cell Phone #	()	Work Phone #	()
Sport (s)		Cell Phone #	()
Year in School (Circle One) Fall '08	1 st 2 nd 3 rd 4 th 5 th		

Are You Allergic To:

Type	Circle One	Explanation
PENICILLIN	YES NO	
SULFA DRUGS	YES NO	
OTHER DRUGS	YES NO	
INSECTS / FOODS	YES NO	

Do You Take Any Medications Regularly? YES NO If Yes, Please List And Explain
 (Include Birth Control, Allergy Medication , Shots, Etc)

Do You Take Any Nutritional Supplements OR "Weight Gainer" Regularly? YES NO If Yes, Please List And Explain

Have you Ever Been Diagnosed with Asthma? YES NO If yes, indicate type and frequency of
 inhaler use:

Do You Wear Contacts or Eyeglasses? YES NO If Yes, What?
 (Glasses, Soft, Hard, Gas Permeable, Extended Wear...)

Do You Have Any Dental Appliances? YES NO If Yes, Please List And Explain
 (Caps, Bridges, Crowns, Retainers, Etc.)

 Student-Athlete Signature

 Date