WELCOME TO OUR CENTER

Player Full Name_____

Nickname_____

Address _____

City _____ State_____ Zip_____

Date of Birth_____ Age_____ Sex: M ☐F☐

Home Ph#_____Cell Ph#_____

E-mail address_____

Guardian Name_____

Best Contact Ph #_____

Athlete History Do you now or have ever had:

☐ double vision ☐diabetes ☐concussion(s) ☐color deficiency ☐glaucoma
☐sinus problems ☐allergies ☐amblyopia ☐learning problems ☐retinal disease
☐eye surgery ☐ headaches ☐ eye turn ☐high blood pressure

Questionnaire

1. Primary purpose for sport training?_____
_____

_____

2. Primary Sport you are looking to improve? _____
_____

3. Sport Position(s)_____