

NAME: _____ (Age) _____

MEDICAL INFORMATION

IN CASE OF EMERGENCY NOTIFY: _____

PHONE: (DAYTIME) _____ (EVENING) _____

FAMILY PHYSICIAN _____ PHONE _____

FAMILY INSURANCE CO. _____ POLICY# _____

PAST MEDICAL HISTORY

(Check giving appropriate information)

IMMUNIZATIONS: _____ Tetanus _____ Polio Booster _____ Measles _____ Mumps
_____ Other _____

_____ Asthma _____ Sinusitis _____ Bronchitis _____ Kidney Trouble _____ Heart Trouble

_____ Diabetes _____ Dizziness _____ Stomach Upset _____ Hay Fever _____ Seizures

_____ Other _____

ALLERGIES: Food _____

(List type) Penicillin or other drug (name) _____

Insect stings/bites _____

Poison sumac, oak or ivy _____

Previous operations or serious illnesses: _____

Any **CURRENT** medication: (List) _____

Special Diet: (Name) _____

Childhood Diseases: _____ Chickenpox _____ Measles _____ Mumps _____ Whooping Cough

Other _____