

MEDICAL INFORMATION

Name _____
(First) (Middle Initial) (Last)

Telephone (____) _____ (____) _____
(Home) (Work)

Personal Physician _____ Phone (____) _____
(Name)

In case of emergency, please contact _____

Phone (____) _____

Special dietary considerations _____

List known allergies _____

List required medications _____

If you are allergic to bee stings, do you have a bee sting kit? _____

Do you wear contact lenses? _____ Are you pregnant? _____

Have you had or do you now have (circle if yes): heart attack diabetes
Asthma angina chest pains drug reactions high blood pressure heart murmur

If you answered yes to any of the above, explain and include the date _____

Do you have any other medical conditions we should be aware of? _____
