



Please complete this form, bring it to the school, and turn it in at registration. This information will be kept confidential and will be used only in a medical emergency. This form will be destroyed after the event.

NAME: _____ DATE: _____
(LAST, FIRST — Please **print** clearly)

CONTACT INFORMATION

A. Emergency Contacts — please list the names, telephone numbers, and the relationships to you of those whom we should contact in case of an emergency.

B. Physician Contact — please list the name and emergency telephone number for your physician.

MEDICAL INFORMATION

C. Specific Medical Problems — please check those medical conditions that you have.

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Adrenal problems | <input type="checkbox"/> Other (list below): |

D. Medications — please list all prescription and non-prescription medications that you take.

E. Allergies — please list allergies you have to specific medications, as well as any serious general allergies you have (e.g., to bee stings, egg products, iodine, etc.).

F. Electrocardiogram — physicians recommend that persons with a known abnormal EKG carry a copy to be used as a baseline in an emergency; you may attach a copy to this form, if desired.

- | | |
|--|--|
| <input type="checkbox"/> No, I do not have a copy of my EKG. | <input type="checkbox"/> My EKG is carried on my person. |
| <input type="checkbox"/> My EKG is attached to this form. | |