MEDICAL & EMERGENCY INFORMATION

(This form must be completed and signed by you and turned in prior to the start of your course)

Name_____ Birth Date_____

Street Address_____

City_____ State_____ Zip_____

Do you have a history of, or do you currently have, any physical limitations that might prevent you from fully participating in this course? ☐Yes ☐No

If **Yes**, please specify any physical limitation_____
_____

Please check those that apply and provide necessary info on reverse side of this form.

Chronic Ailments:
- ☐ Asthma, or other respiratory problems
- ☐ Circulatory or heart problems
- ☐ Diabetes or hypoglycemia
- ☐ Epilepsy
- ☐ Hemophilia, or other bleeding problems

Allergies:
- ☐ Insect bites
- ☐ Bee Stings
- ☐ Foods
- ☐ Drugs
- ☐ Others, if significant

Current medications or pertinent information_____

Blood type_____ Last physical exam ___/_____/_____ (Date) Last tetanus shot ___/___/___ (Date)

Family physician _____ Phone_____

Medical records location?_____Insu. Carrier_____ ID #_____

Who should be notified in case of emergency?

Name _____ Relation_____

Phone_____ _____ _____
Business Residence Mobile

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Education Law and/or Public Health Law of the State of Florida, and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem treatment to the patient, but that any of the above treatment will not be withheld if any of these people cannot be reached.

Signature_____ Date_____