

**MEDICAL AND EMERGENCY INFORMATION**

NAME: \_\_\_\_\_ SEX \_\_\_\_\_(M) \_\_\_\_\_(F)

ADDRESS: \_\_\_\_\_  
Street P.O. Box

\_\_\_\_\_  
City State Zip  
 TELEPHONE \_\_\_\_\_(R) \_\_\_\_\_(B) DATE OF BIRTH: \_\_\_\_\_

**THE PARTICIPANT AND HIS OR HER PARENTS MUST RESPOND TO THE FOLLOWING QUESTIONS AS ACCURATELY AND COMPLETELY AS POSSIBLE:**

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:		ALLERGIES:	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		MEDICATION	
DIABETES OR HYPOGLYCEMIA		BEE STINGS/INSECT BITES	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		FOODS	
CIRCULATORY OR HEART PROBLEMS		OTHERS, IF SIGNIFICANT	
EPILEPSY			

**DETAILS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_ BLOOD TYPE: \_\_\_\_\_

CURRENT MEDICATIONS IF ANY: \_\_\_\_\_

DOES THE ABOVE NAMED INDIVIDUAL HAVE ANY MEDICAL CONDITION THAT MAY AFFECT PARTICIPATION?

IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE MAKE SURE YOU HAVE FILLED IN ALL THE NECESSARY INFORMATION**