

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 information 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 ____/____/____ Last tetanus shot ____/____/____
Date Date Date

Family physician _____ Phone _____

Medical records location? _____

Insurance 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 _____