FORM 2 -- MEDICAL & EMERGENCY INFORMATION

(This form must be completed and signed by you or your parents (if you are a minor) and turned in prior to the start of your course.)

Name ______________________________ Birth date _______ Sex _____

Address ____
No. Street 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 missing or injured bodily parts, weakness, eyeglasses, contacts, hearing aids, etc. ______________________

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Do you have any learning disability that might prevent you from fully participating in this course? _______ Yes _______ No If yes, please specify ______________________

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 _______________ Date of last tetanus shot ______________________

Family physician name ______________________________ Phone _______________

Date of most recent physical examination ______________________

Where are your medical records kept? ______________________________________

Insurance Carrier ______________________________ Insurance ID #____________

Who should be notified in case of emergency?

Name ______________________________ Relation ____________

Phone ________________ (B) ________________ (R)

Name ______________________________ Relation ____________

Phone ________________ (B) ________________ (R)

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 ______________ and on the staff of any hospital holding a current operating certificate issued by the Department of Health of the State of ______________. It is understood that this authorization is given in advance of any specific 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 advisable. It is understood that effort shall be made to contact the above people prior to rendering 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 ____________
Applicant, or Parent/Guardian (if a minor)