Participant Medical Information Form

Name:_____ Grade:_____ Age:_____

Address:_____

City, State, Zip Code:_____

Home Phone:_____

Family Physician:_____
Address:_____
City, State, Zip Code:_____
Phone:_____

In case of emergency contact:

Name:_____ Phone:_____

Relationship:_____

Name:_____ Phone:_____

Relationship:_____

Medical Information

Please mark an "X" next to any medical condition that applies to your current of past medical history. Please use the additional space to briefly explain.

____Asthma	_____
____Diabetes	_____
____Emphysema	_____
____Epilepsy	_____
____Heart Problems	_____
____Allergies	_____
____Other	_____

Medications (List any medications you are currently taking)
_____ Dosage_____ Times_____
_____ Dosage_____ Times_____
_____ Dosage_____ Times_____

My son/daughter, _____, may receive the medication listed above at the specified times by attending seeing the nurse of emergency medical technician during the MiniTHON.

Parent Signature:_____ Date:_____