LAST NAME ____________________ FIRST INITIAL ______

Health Form

Date of Birth: ____________________

Address: ____

City: ____________________ State: __________ Zip: __________

List all prescriptions and non-prescription medicines currently being taken:

____

List any medical allergies : ______________________________

Other allergies (food), insect stings, etc.): ______________________

Medical History: (Circle any of the following conditions you currently have or ever had)

Asthma   Back Surgery   Heart Problems   Stroke   Seizures

Chronic Back Problems   Migraines   Diabetes   Polio

If diabetic are you insulin dependent? ______Yes ______No

Date of last tetanus immunization: ____________________

Describe any physical conditions that will require special assistance during the

workshop: ______________________________________

In the event of any emergency, I understand that first aid will be administered. I further understand that in case of as serious injury or illness, I hereby give my permission to the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery.

_____Yes _____No

Signature: ______________________________

Date: ______________

Person to contact if case of an emergency:

Name: ______________________ Phone #: (___)______________

Address: ____

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