

Medical Information Form

Workshop Title _____

Name _____

Please briefly describe any medical problems or concerns that you have of which we should be aware:

Please list any medications you are currently taking

1) _____ dosage _____

2) _____ dosage _____

3) _____ dosage _____

Please list any medications, food, etc. to which you are allergic:

1) _____

2) _____

3) _____

Please list the name and phone number of your family physician:

Person to contact in case of emergency _____

Address _____

City _____ State _____ Zip _____

Phone (w) _____ (h) _____

Relation to you _____