

## MEDICAL INFORMATION

THIS IS THE MEDICAL INFORMATION FORM FOR \_\_\_\_\_.

INSURANCE COMPANY AND POLICY NUMBER \_\_\_\_\_

ALLERGIES - Please list anything (foods, medicines, etc.) to which you may be allergic.

CHRONIC ILLNESSES - Do you have any condition for which you must regularly take medication or require special care?

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Asthma

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Other

MEDICATIONS - Are you currently taking any medications?

ARE THERE ANY DIETARY RESTRICTIONS OR SPECIAL NEEDS (allergies, vegetarian, etc)?

OTHER CONCERNS - Is there anything else concerning your health that we should know?