

Georgia State Crew Club 2007-2008

MEDICAL INFORMATION FORM

All Team Members, and Volunteers must read, complete and sign this form.
Please list all information requested. **Please print.**

SECTION I – PERSONAL INFORMATION

NAME: _____

LAST FIRST M.I.

ADDRESS: _____

STREET

CITY, STATE or PROVINCE, COUNTRY

PHONE NUMBER: _____

DOB: _____ SEX: M ___ F ___

HT: _____ WT: _____

EMERGENCY CONTACT

NAME: _____

PHONE: _____

RELATIONSHIP: _____

SECTION III – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication? YES ___ NO ___

If "YES", please list names and dosages.

Are you allergic to any type of **medication**? YES ___ NO ___

If "YES", please list. _____
