Confidential Medical Form

This Form must be completed by all accepted applicants and returned by: April 15, 2019

Last Name _____ First Name _____

Mailing Address _____

City_____ State _____ Zip _____

Date of Birth _____ Phone _____ Email _____

Emergency Contact

Name _____

Relationship _____

Daytime phone _____

Evening phone _____

1. Do you have any of the following conditions? (Please check)

❑ Epilepsy/seizures ❑ Bleeding/clotting disorder ❑ Heart disease
❑ Asthma/emphysema ❑ High blood pressure ❑ Diabetes
❑ Other _____

2. Have you ever been told that your **SNORING** is serious enough that it can disturb others? (Please check) ❑ Yes ❑ No
Comments _____

3. Allergies (food, environmental, medication) _____
_____

❑ No known allergies

4. List any medications taken on a daily basis (or attach separate sheet):
_____
_____

❑ Do not currently take medications

5. Do any medications require refrigeration? ❑ Yes ❑ No (List if Yes)
_____

6. Do you have any other medical condition of which the MROP should be aware?
❑ Yes ❑ No (List if Yes) _____

_____

7. Will you have any special medical requirements during this event? ❑ Yes ❑ No

(If Yes, please describe) _____

_____

Name of health insurance carrier _____

_____

Policy number _____

_____

Physician's name _____

Physician's phone _____

I hereby release the above information for use of the MROP staff, site staff, and/or any other Medical personnel who might need to provide care to me during this event.

Signature _____ Date _____